The Lived Experience of Non-English and Limited English Speaking Hispanic Persons
Associated with a Past In-Patient Hospitalization in the United States:

A Phenomenological Study

A dissertation submitted

by

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Abstract

The Hispanic population in the United States faces many challenges such as differences in language, culture, education, and socioeconomics. Research findings suggest that poor acculturation, language barriers and healthcare provider biases are associated with decreased access to care, lack of insurance or underinsurance, underutilization of services, feelings of isolation and powerlessness, which may lead to poor health outcomes. Some improvement in patient satisfaction, decreased rates of miscommunication and improved access to care has been noted with the implementation of the National CLAS standards. Findings from research studies conducted in the community and emergency settings suggest that patients’ perception of care can vary across healthcare settings and geographic locations. In the U.S., there is growing but limited research to the perceptions of the Hispanic non-English or limited English speaking persons related to an inpatient hospitalization experience. This is an important issue to address as patients with language barriers are vulnerable and the individual level support that may be experienced in community settings may not be present in the hospital. Furthermore, in order to close the disparity gap in quality of care, it is essential to examine the healthcare needs of patients at all healthcare settings.

This hermeneutical phenomenological study explored the lived experience of non-English and limited English speaking Hispanic persons associated with past in-patient hospitalization in the United States. Participants were recruited through purposive sampling from area community centers. The researcher conducted 11 participant interviews with non-English speaking and limited English speaking Hispanic persons. Data saturation was reached; six themes and 19 subthemes emerged from the analysis. This hermeneutical phenomenological study provides a voice for this population and contributes to the current body of nursing research.
Chapter I: Significance of the Problem

Introduction

As the United States (U.S.) becomes more culturally and ethnically diverse, healthcare providers are challenged with meeting the health care needs of a diverse patient population. Of all the ethnic minority groups in the U.S. the Hispanic population accounts for 16% of the total U.S. population (U.S. Census Bureau [USCB], 2011). The Hispanic population is one of the largest and fastest growing groups, accounting for one-half of the total U.S. population growth during 2000-2010 (USCB, 2011). The rapid growth of the Hispanic population in the U.S. presents challenges to the health care system. Only 5.4% of nurses (Human Resources and Services Administration [HRSA], 2014) and 6% of physicians (HRSA, 2014) in the U.S. are of Hispanic origin and there are no reported statistics on Spanish fluency among health care providers. In addition, 46.9% of Hispanics report speaking English less than “very well” (USCB, 2010).

The Hispanic population deserves special attention and study due to the inherent differences in language, culture and socioeconomics among its members. There is evidence in the literature to suggest that these factors contribute to poor health care and negative health care experiences (Agency for Healthcare and Research Quality [AHRQ], 2010; Bradley & Mason, 2007; Gardner & James, 2006; Gaston- Johansson, Briggs & Oguntomilade, 2007; Sarver & Baker, 2000; Smedley, Smith & Nelson, 2002). To date, limited research and professional attention have been given to the study of the perceptions of health care as experienced by non-English or limited English speaking patients of Hispanic background. The purpose of this study was to explore the perceptions of this population following an
inpatient hospital experience. In this chapter, the background, problem statement, significance and overview of the methodology of this study are presented.

**Statement of the Problem**

According to the current body of health research literature, disparities related to health care access and health outcomes are greater among Hispanics compared to non-Hispanic Whites. Although there are numerous factors that contribute to healthcare disparities that affect this population, there has been little attention given to the perceptions of non-English or limited English speaking Hispanic persons related to an inpatient experience (Eckhardt, Mott & Andrew, 2006; Gurman & Becker, 2007). The vast majority of health-related research that examined health care experiences and the Hispanic population has been conducted in community health centers and emergency departments. This is a concern because how patients experience health care can depends greatly on the setting.

Many patients experience the greatest disruption to their lives during an inpatient hospitalization episode. Hospitalizations can result in patients feeling physically, emotionally and financially vulnerable (Eckhardt, Mott & Andrew, 2006; Roberts, 1994). For Hispanic patients in the U.S., particularly individuals who have limited proficiency in English, these fears and stressors can also limit their ability to communicate effectively. Ineffective communication can lead to patient safety errors thereby increasing the risk of harm to a vulnerable population (Quan, 2010; Suurmond, Uiters, de Bruijne, Stronks, & Essink-Bot, 2010). Many studies suggest that provider-patient communication and cultural competence are primary factors that affect health care outcomes among minority populations in the U.S. (AHRQ, 2010; Bradley & Mason, 2007; Flores, Laws, Mays & Zuckerman, 2003; Gardner & James, 2006; Gaston- Johansson et al., 2007; Sarver & Baker, 2000; Smedley et al., 2002). Studies also suggest that when effective communication or cultural competence among health
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care providers is not present, patients with cultural or language barriers when compared to those without cultural and language barriers are less satisfied with their care, receive substandard care and perceive being treated with disrespect (Gurman & Becker, 2007; Harari, Davis & Heisler, 2008; Keller, Silberberg, Hartmann & Michener, 2010; Van Ryn & Burke, 2000).

A number of empirical studies have focused on communication or cultural competence. However, these studies are primarily focused on communication barriers as experienced from the perspective of the health care provider rather than the patient (Bernard, 2005; Cioffi. 2006; Gerrish, 2001; Narayanasamy, 2003; Roberts, 1994; Thompson, 2001). Although several studies have examined this phenomenon from the perspective of the patient, they were limited to health care encounters experienced in emergency departments and community health centers.

**Purpose Statement and Research Question**

The purpose of this phenomenological study is to describe the lived experiences of non-English and limited English proficient Hispanic patients associated with a past hospitalization in an acute care setting in the U.S. The research question is: What are the perceptions of Hispanic patients with language barriers regarding an inpatient hospitalization experience?

A hermeneutical phenomenological qualitative method was utilized to explore this question. In qualitative research, the methodologies are inductive processes that allow themes to emerge from the voices of the participants (Cohen, Kahn & Steeves, 2000; Creswell, 2009; Morse & Field, 1995; Rossman & Marshall, 2006; Thomas & Pollio, 2002). An underlying assumption of phenomenology, as a method and a philosophy, is that it is considered to be interpretive in nature. Hermeneutical phenomenology, views the participant and researcher
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as essential components of an interpretive process interacting to describe the meanings of a phenomenon (Bender, Harbour, Thorp & Morris, 2001; Creswell, 2009; Esposito, 2001; Rossman & Marshall, 2006). The participant’s interpretation is based in the individual’s life tradition and past experiences (Cohen, Kahn & Steeves, 2000). This is key, as this methodology acknowledges that participants’ current experiences are influenced by past experiences and there is constant interaction between the individual and the world. (Rossman & Marshall, 2006; Thomas & Pollio, 2002). In order to gain a deeper understanding of phenomena, it is important to explore it within the world context. Unlike other phenomenological methodologies, hermeneutic phenomenology of the Heideggerian tradition does not expect the researcher to set aside or bracket biases and assumptions, but rather to self-reflect throughout the research process and be explicit in stating how the experiences of the researcher relate to the research topic (Laverty, 2003; Munhall, 2007; Thomas & Pollio, 2002).

The hermeneutical approach is especially fitting for exploring phenomena in vulnerable populations, such as Hispanics with language barriers, as it allows individuals of this to group to recount their health care experiences without isolating their life history; thereby allowing for a deeper exploration and understanding of perceptions of the hospital experience. Data obtained from this study could be used to inform the body of knowledge and contribute to this field of research. This study bridges the gap between provider and patient perspectives of the hospitalized encounter as experienced by the Hispanic non-English speaking and limited English-speaking patient.

Background

Hispanic Population
The term Hispanic or Latino is the nomenclature assigned to describe those persons whose ethnic or cultural group originates from Latin America or Spain. These terms refer to all Spanish-speaking ethnic groups (Dayer-Berenson, 2014). Hispanics are the second largest ethnic minority group in the U.S. accounting for 14.8% of the population and are second in rate of growth only to Asian/Pacific Islanders (USCB, 2008). According to the 2000 U.S. census report, 46% of the current Hispanic population immigrated to this country during 1990-2000 (Ramirez, 2004) and accounted for one-half of the country’s growth between 2000-2010 (USCB, 2011). According to the Pew Research Center, 14 Hispanic cultural subgroups currently reside in the U.S.; accounting for 95% of the Hispanic population; Mexicans, 64.6%; Puerto Ricans, 9.5%; Salvadoran, 3.8%; Cuban, 3.6%; Dominicans, 2.9%; Guatemalan, 2.3%; Colombian, 1.9%; Spaniard, 1.4%; Honduran, 1.4%; Ecuadorian, 1.2%; Peruvian, 1.1%; Nicaraguan, 0.8%; Venezuelan, 0.5%; Argentinian, 0.5% (Lopez, Gonzalez-Barrera & Cuddington, 2013).

The Hispanic population in the U.S. experiences disparities in health care access and outcomes at alarming rates despite the focus on eliminating disparities of the health system. There are varying definitions of the term disparities in social science, nursing and public health literature. Disparities have been defined as differences in quality of care provided to a group of people due to racial, ethnic or social influences (Le Cook, McGuire, Lock & Zaslavsky, 2010; Smedley, et al., 2002), unjust and unfair inequalities of health care access or quality of health care delivery (Pan American Health Organization World Health Organization [PAHO WHO], 1999) or a chain of events that lead to differences in environment, health outcomes or health status (Carter-Pokras & Baquet, 2002).

Hispanics in the U.S. have the greatest income and education disparities, with the highest rates of uninsured, poverty and largest decreases in income than any other ethnic group (DeNavas-Walt, Proctor, & Smith, 2010; Kochhar, 2014). According to the 2006 U.S.
census data, only 61% of Hispanics 25 years or older, completed a high school education compared to 89% of the total population (USCB, 2008). Furthermore, in a study of Medicare patients, 33% of elderly people and 53% of Hispanics were illiterate (Baker et al., 2002).

The Hispanic population has been at the center of attention related to health disparities. The 2009 National Health Disparity Report (NHDR) demonstrated that health care disparities among Hispanics persist despite improvements in other core measurements (AHRQ, 2010). When compared to the 2005 NHDR, disparities stayed the same or worsened on the majority of the core measures. For Hispanics, when compared to non-Hispanics Whites, disparities worsened on 70% of the core measures on quality of care and stayed the same on 10% of the core measures. Improvements in quality of care were noted in only 20% of core measures in which Hispanics received better care than non-Hispanic Whites. Quality of care was measured by rates of preventive services received. For preventive care services, when compared to non-Hispanic Whites, Hispanics were less likely to receive pneumococcal vaccination, and breast and colon cancer screening. In addition, Hispanic children were less likely to receive vision checks or information about exercising. In the core measures of quality on disease management, Hispanic patients with diabetes, tuberculosis or a major depressive disorder were less likely than non-Hispanic Whites to receive recommended treatment. Hispanics who were hospitalized were less likely to receive recommended treatment for heart failure, heart attacks, pneumonia and kidney transplantation. In terms of patient safety, Hispanic patients aged 65 and over were more likely than non-Hispanic Whites to receive the wrong medication. In addition, disparities in access to care worsened on 83% of the core measures (AHRQ, 2010).

When compared to non-Hispanic Whites, Hispanics continue to have disparities across all social determinants of health indicators. One measurable indicator from the Centers for Disease Control Health Disparities and Inequalities Report [CHDIR] of particular
interest to this proposed study is preventable hospitalizations. This indicator measured the rate of hospitalizations during 2007 for those conditions that could have been treated in primary care. When compared to non-Hispanic whites, Hispanics had 100,000 more preventable hospitalizations costing $4.2 billion vs. $3.3 billion in medical costs for non-Hispanic Whites (CDC, 2011). Lastly, findings from the 2009 National Health Disparities Report revealed that Hispanic patients who reported lower levels of education, income and public insurance also reported higher levels of difficulty communicating with the health care provider because of language barriers.

Education, language, culture, socioeconomic, insurance status, location of residence and other factors affect how this population fairs in the U.S. health care system. Language and cultural barriers and socioeconomic disparities experienced by Hispanics present this population with complex challenges that must be considered in order to improve health outcomes.

**Summary**

The Hispanic population in the U.S. is a socioeconomically and culturally diverse group. There is a dearth of literature related to the perceptions of health care related to a hospitalization experience and therefore this study will add to this body of knowledge by providing a richer understanding of how patients with language barriers experience inpatient hospitalization. Little attention has been given to the perceptions of this population regarding inpatient hospitalization experiences. Research to date has focused primarily on the experiences of healthcare professionals providing primary or emergent care related to patients with language barriers. This study adds to the body of nursing knowledge and it is anticipated that the findings will inform health care providers and policymakers about the impact of these perceptions on health outcomes experienced by this population.
Conclusion

The Hispanic population in the U.S. faces many challenges such as differences in language, culture, education, and socioeconomics. These factors can create barriers for health care providers to effectively meet the health care needs of this population. This hermeneutical phenomenological study provides a voice for this population and contributes to the current body of nursing research. A review of literature is presented in Chapter Two. The current state of science on Hispanics’ perceptions of care, communication and disparities, as well as relevant health care literature is discussed in greater detail.
Chapter II: Review of Literature

Introduction

A comprehensive review of theoretical, empirical, qualitative and anecdotal literature revealed a limited literature base related to the perceptions of non-English speaking and limited English speaking Hispanic patients regarding their acute care hospitalization experiences. The purpose of this chapter is to review and synthesize what is known about this phenomenon. This literature review encompasses the current state of science on Hispanic healthcare disparities and Hispanic patients’ perceptions of care experienced in primary care, the emergency department and during an acute care hospitalization. Analysis of the literature revealed that Hispanics are a diverse population with socioeconomic, cultural and language barriers. These barriers have proven to be challenging for both healthcare providers and patients in meeting the healthcare needs of this population. Research findings suggest that poor acculturation, language barriers and healthcare provider biases are associated with decreased access to care, lack of insurance or underinsurance, underutilization of services, feelings of isolation and powerlessness, which may lead to poor health outcomes. In contrast, linguistic and culturally specific interventions have been associated with improved patient satisfaction, decreased rates of miscommunication and improved access to care. The majority of studies conducted regarding the Hispanic healthcare experience have largely utilized quantitative methods. The overall majority of past studies conducted on this topic have been from the perspective of healthcare providers, mainly physicians and to a lesser extent nurses. What have not been fully explored are Hispanic patients’ perceptions, particularly non-English proficient (NEP) to limited English proficient (LEP) and LEP patients’ perceptions, of care during a hospitalization.
Process of the Literature Search

This literature review was conducted searching various governmental and organizational agencies’ publications, as well as the following electronic databases: CINAHL, MEDLINE, Pub Med, ProQuest and Google Scholar. The search included publications from 1991-2012. This time span reflects the period in which the majority of research on Hispanics has been conducted. Further research studies were found through search of the grey literature. The following key terms were used: Hispanics, disparities, patients, hospitalization, quantitative and qualitative research, perceptions of care, patient satisfaction and language barriers. Articles not written in English and studies limited to the pediatric population were excluded.

Literature Review

The review of literature includes a discussion of governmental and organizational agencies’ approach to reducing health disparities in Hispanics, research that relates to the Hispanic healthcare experience and perceptions of care within the United States (U.S.) healthcare system from outpatient to hospitalization. Of the 102 research articles included in this review, 56 were quantitative research studies, 44 were qualitative research studies, and 5 were mixed-method studies.

Health Disparities. This section includes a discussion of the definitions of disparities present in the literature. Specific data on Hispanic healthcare disparities are from the National Health Disparities Report (NHDR), Centers for Disease Control and Prevention Health Disparities and Inequalities Report (CHDIR) and 25 published research articles in which health disparities in the Hispanic population were the focus.
The literature revealed that health and healthcare disparities of Hispanics have been studied from various perspectives: disease prevalence (Apostolopoulos et al., 2006; Boucher & Schenker, 2002; Much, Martin, & Gepner, 2000); healthcare utilization (Adams, Horn, & Bader, 2007; Bernstein et al., 2002; Coffman, Shobe, Dmochowski, & Fox, 2007; Cook, McGuire, & Miranda, 2007; Derose & Baker, 2000; Gavin, Adams, Hartmann, Benedict, & Chireau, 2004; Hunt, Voogd, Soucy, & Lingworth, 2002; Jacobs et al., 2001; Sarver & Baker, 2000; Weinick, Jacobs, Stone, et al., 2004); health outcomes (Leslie, Diehl, & Galvin, 2006; Urizar & Sears, 2006); health literacy (Coffman & Norton, 2010; Fitzgerald, Chakraborty, Shah, Khuder, & Duggan, 2003; Kaphingst, K.A. et al., 2015; LaChausse, 2001; Rodriguez, S. A., Roter, D. L., Castillo-Salgado, C., Hooker, G. W., & Erby, L. H., 2015; Sarkar, Fisher & Schillinger, 2006); insurance coverage (Vitullo & Taylor, 2002; Weinick et al., 2004); and medication compliance (Gilmer et al., 2009; Pylypa, 2001; White, R. O., Osborn, C. Y., Gebretsadik, T., Kripalani, S., & Rothman, R. L., 2013).

In order to understand the phenomenon of healthcare disparities, there must be a discussion of what is meant by the term disparities. There are varying definitions of the term disparities in social science, nursing and public health literature. Disparities have been defined as differences in quality of care provided to a group of people due to racial, ethnic or social influences (Le Cook, McGuire, Lock, & Zaslavsky, 2010; Smedley, Stith, & Nelson, 2002), unjust and unfair inequalities of healthcare access or quality of healthcare delivery (Pan American Health Organization World Health Organization [PAHO WHO], 1999) or a chain of events that lead to differences in environment, health outcomes or health status (Carter-Pokras & Baquet, 2002).

To that end, researchers continue to examine a variety of factors that may have a negative effect on health outcomes. Genetic, social and economic factors, known as determinants of health, have been discussed in health literature (Tarlov, 1996; Wilkinson &
Marmot, 2003). Genetics research has made many strides in providing data that improve the treatment and understanding of illness. However, extensive research has also demonstrated that social determinants of health, such as income, education level, societal norms or bias, work and living conditions, can positively or negatively affect the health outcomes of a population of people in a short period of time (Byrd, Fletcher, & Menifield, 2007; Smedley, Stith, & Nelson, 2002; Wilkinson & Marmot, 2003). For example, loss of income or insurance can lead inability to treat an illness. The role of acculturation and its relationship to disparities have been measured to some extent (Beck, Froman, & Bernal, 2005; Beck, 2006; Gibson, Diaz, Mainous, & Geesey, 2005; Wilkinson et al., 2005). The findings of these studies suggest that improving medical care alone will not completely change health outcomes. Simply stated, correcting health inequities requires addressing social inequities (Braverman & Gruskin, 2003; Irwin et al., 2006; Zambrana & Carter-Pokras, 2010).

In the U.S., several federal agencies and programs have focused their research efforts on examining healthcare practices and healthcare disparities in minority groups (Agency for Healthcare Research and Quality [AHRQ], 2005; Centers for Disease Control and Prevention [CDC], 2011; U.S. Department of Health and Human Services [USDHHS], 2011. Both the CDC and Healthy People 2020 include new indicators specifically aimed at measuring the progress in reducing those diseases or conditions associated with social determinants of health (CDC, 2011; USDHHS, 2011). In continuing the commitment to improve the overall health of the nation, Healthy People 2020 identified four overarching goals using the Social Determinants of Health framework (USDHHS, 2008): 1) eliminate preventable disease, 2) eliminate health disparities and achieve health equity, 3) promote good health by creating safe work and living conditions, and 4) promote prevention through healthy behaviors.

According to the 2009 U.S. Census Bureau Report on rates of poverty and insurance coverage during 2007-2009, all minority groups have socioeconomic disparities when
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compared to the total population. However, Hispanics have the greatest income and
education disparities with the highest rates of being uninsured, living in poverty and largest
decreases in income than any other ethnic group (DeNavas-Walt, Proctor, & Smith, 2010).
Data from the 2008 NHDR demonstrated that Hispanic LEP or NEP patients when compared
to English proficient patients were more likely to be uninsured (36.9% vs. 16.6%). Generally
speaking, LEP patients were noted to have no usual source of care (52% vs. 44%). Using data
from the 2007 California Health Interview Survey, the 2010 NHDR found that when
compared to non-Hispanic Whites, Hispanics were less likely to be insured. Hispanic
subgroup variation revealed that when compared to Whites, Hispanics from South America
were the most likely group to have insurance when compared to Whites (90% vs. 94%),
Mexicans were the next likely group (81.1% vs. 94%) and lastly Central Americans (73.6%
vs. 94%). The authors of the NHDR conducted multivariate analyses to examine the
relationship of race, education level and insurance coverage to quality of care. Repeated
regression analysis suggested that while insurance coverage is a strong predictor of quality of
care, it does not fully explain the disparities in quality or access to care (AHRQ, 2010).

In examining access to care, utilization of services by Hispanic patients was examined
in several studies and found to be underutilized across the spectrum of healthcare settings
(Bernstein et al., 2002; Coffman et al., 2007; Cook, McGuire, & Miranda, 2007; Derose &
Baker, 2000; Gavin et al, 2004; Jacobs et al., 2001; Keller, Silberberg, Hartmann, &
Michener, 2010; Sarver & Baker, 2000). Reported barriers that contributed to the
underutilization of services were patient and healthcare provider communication difficulties,
lack of patient knowledge regarding available services/resources, and patient perceived
discrimination from healthcare providers (Keller et al., 2010). On the other hand,
communication barriers can lead to inefficient management of care. Waxman and Levitt
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(2001) found that diagnostic studies were ordered at a higher rate for LEP or NEP patients when compared to English speaking patients.

The most comprehensive information on minority health can be found in the NHDR. The CDC’s inaugural issue of CHDIR was intended to complement not duplicate the NHDR. As indicated earlier, AHRQ examined and analyzed national healthcare databases for trends in quality of care and access to care among non-Hispanic Whites and ethnic minority groups. Core measures for quality of care were patient centeredness, patient safety and timeliness of care. Core measures for access to care were insurance coverage, usual source of care, those without a usual source of care for financial or insurance reasons, and delays in treatment. The NHDR presents a summary of trends, which identifies differences in care received among ethnic minority groups when compared to care received by non-Hispanic Whites and tracks those differences over time.

As noted earlier, in the 7th released report, the 2009 NHDR indicated that healthcare disparities among Hispanics persist despite improvements in other core measurements (AHRQ, 2010). Also previously noted from the CHDIR of particular relevance to this study is increased rate of preventable hospitalizations (CDC, 2011). Hospitalized Hispanics were less likely to receive recommended treatment for heart failure, heart attacks, pneumonia and kidney transplantation. In terms of patient safety, Hispanic patients aged 65 and over were more likely than Whites to receive the wrong medication. Access to care continued to be a problem as disparities worsened on 83% of the core measures (AHRQ, 2010).

Another noted disparity reported in the 2010 NHDR, communication with the healthcare provider, was measured as part of the core measure of patient-centered care. Participants responded to a quantitative survey that included questions related to perceived communication behaviors of careful listening, perceived respect and time spent with
healthcare provider. Between 2002 and 2007, Hispanic adults who had a physician visit within the last 12 months were significantly more likely than non-Hispanic Whites to report poor communication with a healthcare provider. Additionally, incidences of poor communication were significantly higher among socioeconomic classes of poor, near-poor and middle-income than for higher income people. Communication disparities were also noted across educational levels. Hispanics with a high school education were more likely than non-Hispanic Whites with the same level of education (11.4% vs. 8%) to report poor communication with their healthcare provider. This trend was also noted for provider-patient communication during hospitalization. Overall, only 5% of the patients reported poor communication with a healthcare provider. However, it was found that when compared to non-Hispanic Whites, all minority groups were more likely to report poor communication with nurses. When compared with non-Hispanic Whites, Hispanics were more likely to report poor communication with nurses but not with doctors. Further, those patients with less than a high school education were more likely to report poor communication with both physicians and nurses. Finally, data from the 2007 NHDR revealed that patients in California who did not speak English well at all were less likely than patients who speak only English to find it easy to read the instructions on a prescription bottle (75.1% vs. 95.4%). When compared to non-Hispanic Whites, Hispanics continued to have disparities across all social determinants of health indicators.

**Governmental and healthcare agency policies**

Recognizing the impact of socioeconomic, cultural and communication issues on healthcare disparities, the Office of Minority Health (OMH) has partnered with other federal agencies and healthcare organizations to reduce healthcare disparities through the development of healthcare policies that address the specific needs of ethnic minority groups
and culturally appropriate evidence-based interventions (OMH, 2001). OMH (2001) defined culturally and linguistic appropriate services (CLAS) as, “healthcare services that are respectful of and responsive to cultural and linguistic needs” (pg. 5). Examples of language services identified included language interpreter services as well as the presence of hospital signage and health education materials translated into languages. Failure to provide language services can be considered a form of discrimination and a violation of the Civil Rights Act of 1964, Title VI. Title VI requires all facilities receiving federal monies to ensure access to those who lack or have limited English language proficiency (USDHHS, 2012).

OMH published 14 national CLAS standards for healthcare (OMH, 2000). Categorized into three groups, i.e., mandates, guidelines and recommendations, the CLAS standards were developed to serve as guidelines for use by other organizations, lawmakers, and accreditation agencies. Healthcare agencies that received federal funds were mandated to comply with standards 4 through 7, which pertained to providing language interpretation services and translated health education materials in the preferred language of the patient regardless of the size of the represented community. Interpreters must be certified as language interpreters unless the patient requests to have a friend or family participate. Also addressed in these mandates was informing patients of the right to receive language interpretive services and translated materials. After thirteen years the enhanced CLAS standards were published. These revised standards were meant to provide clarity to the 2000 CLAS standards (OMH, 2014, para. 1). It is now 15 standards with standards 5 through 8 pertaining to the provision of language assistance. Similar to the 2000 CLAS standards, healthcare providers are required to provide language interpretative services free of charge. Patients are to be informed of the right to these services in both a written and verbal form in a public space with clear signage. The language of the standard pertaining to the use of interpreters has now changed. The standard now calls for healthcare providers to “Ensure the
competence of individuals providing language assistance, recognizing that the use of untrained individual and/or minors as interpreters should be avoided” (OMH, 2013, pg.1). In the clinical setting, the Joint Commission has used the OMH’s CLAS standards to develop guidelines for addressing care for patients with language barriers. However, the guidelines were recommendations only and their implementation had been slow in healthcare institutions (Joint Commission on Accreditation of Healthcare Organization, 2006). In 2012, The Joint Commission (TJC) released new standards that address patient-centered communication (TJC, 2014, pg.1). These standards incorporated the overall intent of the CLAS standards. A major criticism of the CLAS standards by private practice providers and small healthcare agencies is the cost required to implement such strategies (Ku, 2005; Robert Wood Johnson Foundation [RWJF], 2004). The United States, Australia and England have developed health policies on a national level in an effort to address language barriers and disparities. Currently, Australia is the only country in which the costs of language interpreter or translation services for non-English speaking patients are covered by the government. In the U.S. there are federal dollars available to states that provide interpreter services to Medicaid or State Children’s Health Insurance Program (SCHIP) recipients. However, these are matching dollars and some states elect not to pay for these services or may be unaware of the availability of matching funds (The National Health Law Program & The Access Project, 2004). To date, 13 states provide direct reimbursement to agencies or providers (Youdelman, 2009). Currently, the federal government does not provide any payment for language interpreter services for Medicare recipients.

Summary.
Much has been written and extensive research has been conducted to examine how social and economic variables, known as social determinants of health, affect health outcomes of the various populations living in the U.S. Research findings from this body of
literature suggest that the causes of healthcare disparities in Hispanics are multivariate and complex. In an attempt to decrease or close the health disparities gap, policies and guidelines are slowly being implemented through the collaborative efforts of federal agencies, healthcare and community organizations. Ongoing research is required since there is inadequate evidence regarding effectiveness of specific interventions in reducing specific disparities among certain defined subpopulations (CDC, 2011; Joint Commission, 2010). This research could contribute to understanding why some disparities are worsening while others are improving, despite the implementation of healthcare policies and ongoing implementation of culturally and linguistically appropriate services.
**Hispanic patients and perceptions of care.** This literature review revealed 46 research studies conducted on Hispanic patients’ perception of their healthcare experiences in the U.S. healthcare system. The Hispanic population in these studies is discussed as a whole, as comparison groups of English proficient (EP) versus NEP to LEP or as subgroup populations based on ethnicity or country of origin. Of these, 27 were quantitative studies, 16 qualitative studies and 3 mixed-method studies. Of the quantitative studies, only one was a randomized control trial (Bagchi et al., 2010). The other quantitative studies were 4 descriptive, 8 cross-sectional, 3 secondary data analysis and 8 correlational studies. Of the 16 qualitative studies, 3 were grounded theory, 2 were participatory action research, 7 used semi-structured interviews, and 4 used focus groups. Lastly, 3 studies were conducted using data from national surveys. While many of the studies were conducted in the U.S., the majority of them were conducted in Texas, Colorado, Arizona and California on the west coast and in North Carolina, New York, Philadelphia and Massachusetts on the east coast. Three research studies were conducted in Michigan. The Hispanic sub-population most often examined was Mexican Americans (Adams, Horn, & Bader, 2007; Bender, Harbour, Thorp, & Morris, 2001; Campesino, 2009; Rodriguez, Chen, & Rodriguez, 2010; Warda, 2000).

The literature revealed that perceptions of Hispanics have been explored to understand their living with an illness (Bergland, Heuer, & Lausch, 2007; Caban, Walker, Sanchez, & Mera, 2008; Cabassa, Lester, & Zayas, 2006; Campesino, 2009; Fatone, Moadel, Foley, Fleming, & Jandorf, 2007; Heuer & Lausch, 2006; Karasz & Watkins, 2006; Urizar & Sears, 2006); management of an illness (Gilmer et al., 2009; Pylypa, 2001; Sarkar, Fisher, & Schillinger, 2006; Zayas & McLean, 2007); utilization of screening practices (Apostolopous et al., 2006; Gavin et al., 2004; Gurman & Becker, 2008; Lopez-Quintero, Shtarkshall, & Neumark, 2000), or health practices associated with pregnancy (Tandon, Parillo, & Keefer, 2005).
For the purposes of the proposed study, a more in-depth discussion of Hispanic patients’ perception of care within the U.S. healthcare system is needed. The next 4 sections discuss findings of studies of providers’ perception of caring for Hispanics and Hispanic patients’ perceptions of experiences in primary care, the emergency department and during hospitalization.

Providers’ perceptions of caring for Hispanic patients. Although providers’ perceptions of caring for Hispanic patients are not directly related to the proposed study, it is important to briefly discuss what is currently in the literature regarding the perspective of healthcare providers when caring for NEP or LEP Hispanic patients; this information may add insight to understanding Hispanic patients’ healthcare experience. Understanding what occurs during the healthcare encounter between Hispanic patients and providers has been the aim in the majority of the studies; focusing primarily on communication barriers from the perspective of the physician provider (Bernard, et al., 2006; Hornberger, Itakura, & Wilson, 1997; Fernandez et al., 2004; Kuo & Fagan, 1999; M O’Leary, Federico, & Hampers, 2003; Park et al., 1999).

Because many Hispanics encounter language barriers, it is equally important to examine providers’ perspectives of caring for those who speak a language different than the provider. Overall, studies report that providers’ perceived language barriers affected delivery of patient care. The most frequent recurrent themes reported by healthcare providers were time constraints, feelings of frustration, concerns about patient safety, lost communication and decreased satisfaction when caring for patients with language barriers (Bernard et al., 2006; Gonzalez-Espada, Ochoa, & Vargas, 2006; RWJF, 2004; Elderkin-Thompson, Silver, & Waitzkin, 2001; Warda, 2000). Poor collaboration between interpreters and healthcare providers was identified as a barrier to effective communication (Cioffi, 2003; RWJF, 2004; Gerrish, Chau, Sobowale, & Birks, 2004; Johnson, Noble, Matthews, & Aguilar, 1999; Lee,
Lansbury, & Sullivan, 2005). Anglo-centric values orientation prevails in English speaking countries and may be associated with avoiding or delaying utilization of interpreter services (Cioffi, 2003; RWJF, 2004; Irvine et al., 2006; Lee et al., 2005; Warda, 2000). Time constraints and lack of institutional or financial resource support were the most frequently reasons cited by providers for not utilizing interpreters (Mayo et al., 2007). Time constraints were examined in a time-motion study conducted during office visit encounters between healthcare providers and NEP patients in which an interpreter was present. Tocher and Larson (1999) examined physicians’ perceptions of time spent with patients requiring an interpreter versus the actual time spent. Study findings revealed that despite physicians’ perceptions of increased time spent with NEP patients, timed audio-taped studies of provider-patient encounters utilizing an interpreter demonstrated no significant timed difference in length of visit between NEP and English speaking patients ($p < .01$). Similarly, Meeuwesen, Harmsen, Bersen & Bruijnzeels (2006) found that physicians actually spent less time with language discordant patients. This is in contrast to several studies, in which providers perceived that time delays were encountered in waiting for an interpreter to become available and thereby resulted in delays in treatment (Gonzalez-Espada, Ochoa, & Vargas, 2006; RWJF, 2004; Tocher & Larson, 1999). However, at the time of this literature review, there were no available studies of time-motion interpreter availability. When an interpreter was involved, the dynamics of the patient-provider relationship changed; the interpreter became the liaison between the provider and patient. The impact of interpreters on the relationship between patient and provider emerged as a concern to providers in the discussion of the findings in several studies. Healthcare providers expressed concerns over lost nuances in communication (Cioffi, 2003; Elderkin-Thompson et al., 2001), and quality of interpretation skills, specifically verbatim translation (Cioffi, 2003; Lee et al., 2005). Bilingual workers were regarded as the preferred face-to-face translator, because they were readily available.
and often there was an established rapport between the interpreter and the healthcare provider (Schenker, et al., 2011; Elderkin-Thompson et al., 2001; Johnson et al., 1999).

Several studies were conducted to examine the provider-patient communication dynamic when interpreters of any kind were utilized during the healthcare encounter. From these studies, concerns about compromised patient safety and lost communication were voiced when ad hoc interpreters, that is, persons not professionally trained as interpreters were utilized (Elderkin-Thompson et al., 2001; Flores et al., 2003).

Elderkin-Thompson et al. (2001) focused on nurses as interpreters. This study was part of a larger study that examined mental health issues in primary care. The aim of this study was to examine the accuracy of medical interpretations provided by nurses untrained in medical interpreting. A total of 175 patients consented to have their visit with the physician video or audio recorded; 21 of these patients spoke only Spanish and did not have a family member present to interpret, thereby requiring the nurse interpreter. The encounters were transcribed and translated by two research assistants. Medical charts from follow-up visits were also reviewed to verify patient adherence. The authors described a detailed method of data analysis. The findings demonstrated that communication errors increased with the complexity of the medical problem, with poor collaboration between the physician and nurse and when both the nurse and physician treated the patients’ comments as insignificant. The authors suggested that the nurses may have been concerned about appearing disrespectful of the physician as an authority figure and therefore were reluctant to challenge the physician when misinterpretation was obvious. Additionally, some of the nurse-interpreters were viewed as attempting to use leading questions and responses based on what they believed the physician expected. Cultural idioms were not discussed with the physician and were treated as insignificant. The authors stated that exploration of the nurse as interpreter was important because of the trend by physicians to hire bilingual nurses. However, the authors did not
discuss or explore the encounters in which family members were used as interpreters. This study would have been stronger if all encounters involving an untrained medical interpreter were analyzed, not just the nurse interpreter encounters.

Interviewing the nurses and physicians would add credibility to results. Hiring bilingual healthcare workers has not been a straightforward or ideal solution as previously suggested. In a qualitative study conducted by Johnson et al. (1999), examining the experiences of 81 self-reported bilingual workers; workers spoke of the benefits and challenges of interpretation. Bilingual interpreters spoke of enjoying the ability to speak to patients in another language, but expressed concerns about managing the dual responsibilities of providing language interpretation and their primary role within the institution. Workers reported having varying levels of language fluency which influenced their level of patient interaction. Levels of language fluency and interpretation ranged from social conversation to more complex communication. Lastly, workers considered their bilingual ability as a skill in which level of fluency should be matched appropriately with the level of interaction. For example, social interactions with patients may be appropriate with an untrained interpreter, but discussions regarding medical treatment should be referred to a professional interpreter.

Providers acknowledged that use of ad hoc interpreters was not the gold standard for providing patient care; however, it was perceived as better than not utilizing an interpreter at all. When no interpreters are available, healthcare providers tend to use nonverbal language or speak with little fluency, what is referred to as “get by” language to communicate with patients. These communication strategies were also noted in the Park, et al. (2005) study in which the experiences of U.S. medical residents in providing culturally appropriate care were explored. This focus group study included a purposive sample of medical residents who were affiliated with academic medical centers from various geographic locations and medical specialties. Sixty-eight respondents participated in a qualitative study, in which focus groups
and semi-structured interviews were conducted. From this pilot, the authors noted that residents focused on language differences when asked to discuss culture. During all subsequent interviews, participants were asked to focus on all aspects of cultural awareness, not just language. All sessions were audiotaped and transcribed. The essential findings of this study suggested that physicians associated cultural and linguistic skills with improved quality of care in culturally diverse populations. Residents reported administrative support as nominal with under resourced linguistic services. The importance of the quality of the interpreter was further emphasized when Preloran, Browner and Lieber (2005) found the interpreters’ approach may actually influence patients’ decision making. Not surprisingly, levels of satisfaction for patients and physicians were highest with professional interpreters or bilingual providers (Andrulis, 2002; Brooks et al., 2000; Garcia & Duckett, 2009; Garrett, Dickson, Young, Whelan, & Forero, 2008; Hadziabdic, Heikkilä, Albin, & Hjelm, 2009; Hornberger, Itakura, & Wilson, 1997; Jones, 2012; Kuo & Fagan, 1999; Morales, Cunningham, Brown, Liu, & Hays, 1999; Simon et al., 2013). However, in spite of the aforementioned concerns about language barriers and OMH standards, healthcare professionals continue to provide care to patients with language barriers without having or employing language interpretation services (Johnson, et al., 1999; Martinez-Gibson & Gibson, 2007; O’Leary, Federico, & Hampers, 2003; Park, et al., 2005; Schenker, et al., 2011; Vandervort & Melkus, 2003).

A few studies added to the existing literature by examining healthcare providers’ perceptions of cultural competence, race and ethnicity and their impact on care of the patient (Fernandez, et al, 2004; Hornberger, Itakura, & Wilson, 1997; Mayo et al., 2007; O’Leary, Federico, & Hampers). In one quantitative study of 116 patients and 48 physicians conducted by Fernandez, et al. (2004), physicians who perceived that they were culturally competent received higher ratings on processes of care by patients. In a study by Warda (2000),
Mexican Americans also associated communication as an essential skill in providing culturally competent care. This focus group study examined 22 Mexican American patients’ and nurses’ perceptions of cultural competence. Semi-structured interviews were conducted in community-based organizations. The data collection methods and the subsequent data analysis were based on grounded theory methodology. From the findings, the authors identified valuing, system support, personalismo (i.e., the ability to relate to the patient), and cultural comprehension as four concepts that were perceived as leading to positive outcomes for a congruent healthcare experience. The use of Spanish and nonverbal communication was considered a form of system support by healthcare professionals. Patients’ perceived friendly interaction, such as listening, making eye contact and using physical touch, as well as, using a few words spoken in Spanish to be essential in building a trusting relationship with their provider. However, cultural conflict can occur when the demands of practice or anglo-centric values of some providers serve as a barrier to building this relationship (Warda, 2000). The literature reflected that many providers agreed that cultural competence is an important facet in providing care to a culturally diverse patient population, yet the commitment to obtaining the required education is lacking (Gonzalez-Espada, Ochoa & Vargas, 2006; Narayanasamy, 2003; Park, et al., 2005; RWJF, 2004).

Summary. All of the studies reviewed in this section sought IRB approval. All of the quantitative studies in this section reported sufficient sample sizes and utilized appropriate statistical methodologies. Equally, the qualitative studies described in detail the process of the data collection, process of reaching data saturation and data analysis. The review of the literature revealed that providers do not consistently provide culturally and linguistically appropriate care to the diverse patient population despite awareness that it is a necessity for quality patient care. It is evident from the literature, that there is a greater focus on addressing language needs over cultural needs. This may be due to the perception that communication is
a greater need. Furthermore, provider satisfaction with the care of the Hispanic NEP or LEP patient was associated with the ability to effectively communicate with the patient. Lack of cultural competence education and limited institution and resource support are significant barriers to providing linguistically and culturally appropriate care to patients (Cioffi, 2003; Gerrish et al., 2004; Narayanasamy, 2003; Park et al., 2005; Thompson, 2001). Furthermore, patient education and therapeutic communication are roles traditionally held by nursing. Nurses are expected to establish a therapeutic relationship with patients and to determine what the patients’ needs are during hospitalization and at discharge. However, time constraints, the busy hospital environment, and cultural and linguistic differences, served as powerful barriers to establishing this relationship (Cioffi, 2006; Bernard, 2005; Pytel, 2009). Yet, once trust is gained, interpreters are perceived to be invaluable members of the healthcare team to the provider and patient.
Hispanics and Community Health and Primary Care. This section includes reports from 18 qualitative, 4 mixed method studies and 17 quantitative research studies. The examination of the Hispanic patient experience in primary care has been varied. The majority of the studies focused specifically on understanding language barriers and their impact on various aspects of the patient care experience, i.e., utilization of interpreters and their impact on patient satisfaction (Lee, Batal, Maselli, & Kutner, 2002) or patient safety (Elderkin-Thompson et al., 2001; Irvine et al., 2006). Few studies aimed to understand patients’ perceptions of cultural competence or perceived bias of the provider toward the patient (Castro & Ruiz, 2007; Johnson, Saha, Arbelaz, Beach & Cooper, 2004; Warda, 2000). Other concepts such as access to primary care (Carter-Pokras, et al., 2008; Keller, et al., 2010) and utilization of primary care services (Coffman, et al., 2007; Derose & Baker, 2000; Jacobs, et al., 2001) have been examined. Studied to a limited extent are patient perceptions of quality of care (Bender, Harbour, Thorp, & Morris, 2001; Gaston- Johansson, Hill-Briggs, Oguntomilade, Bradley, & Mason, 2007; Morales et al., 1999; Preloran, Browner, & Lieber, 2005; Rodriguez, Chen, & Rodriguez, 2010; Tandon et al., 2005).

The patients’ perspective of the patient-provider interaction was most often examined through quantitative patient satisfaction surveys in which the assessment of the interaction was a minor component of the overall survey. Weech-Maldonado, Fongwa, Gutierrez and Hays (2007) conducted a secondary data analysis study utilizing data from the 2002 Consumer Assessments of Healthcare Providers and Systems (CAHPS) survey administered to 125,369 Medicare enrollees. CAHPS data from New York, New Jersey, Florida, California and “other states” that addressed certain quality of care and provider communication indicators were analyzed: 1) timeliness of care, 2) helpfulness of staff, 3) provider communication, 4) getting care needed and, 5) health plan customer service. Data from Hispanics (8,463) and non-Hispanic white (98,320) respondents were then compared.
Hispanic respondents were further categorized according to state and primary spoken language. Findings revealed differences in perception of some indicators of quality of care between Spanish-speaking Hispanics and English-speaking Hispanics; as well as, between Hispanics and non-Hispanic Whites.

English-speaking Hispanics when compared to Whites reported perceived decreased quality of care on 4 out of the 5 indicators; timeliness of care, helpfulness of staff, getting care needed and health plan customer service ($p < .001$). Similarly, Spanish-speaking Hispanics when compared to Whites reported perceived decreased quality of care for timeliness of care ($p < .001$); provider communication ($p < .01$) and staff helpfulness ($p < .001$). But Spanish-speaking Hispanics reported better experiences in obtaining needed care when compared to Whites ($p < .01$).

Finally, Spanish-speaking Hispanics when compared to English-speaking Hispanics reported decreased satisfaction with timeliness of care ($p < .05$), staff helpfulness ($p < .001$), and provider communication ($p < .01$). However, Spanish-speaking Hispanics reported better experiences in obtaining needed care when compared to English-Speaking Hispanics ($p < 0.001$). Regional differences in the findings were also noted. In all states surveyed, when compared with Whites, English-speaking Hispanics reported less favorable experiences with timeliness of care and getting needed care; with staff helpfulness in California ($p < .10$) and New York/New Jersey ($p < .01$); and with provider communication in CA ($p < .05$). Spanish-speaking Hispanics reported worse experiences than Whites with timeliness of care in Florida, California, New York/New Jersey ($p < .001$), and other states ($p < .05$); with provider communication in California ($p < .001$), New York/New Jersey and other states; with staff helpfulness in California, New York/ New Jersey and other states ($p < .01$); and with health plan customer service in New York/New Jersey ($p < .05$). Comparatively, Spanish-speaking Hispanics had more favorable experiences than Whites with getting needed care.
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care in Florida ($p < .01$) and other states ($p < .001$); and with health plan customer service in Florida ($p < .10$) and other states ($p < .005$).

This study was the first to also demonstrate regional differentiation of findings among Hispanics. Researchers offered levels of acculturation as a possible reason for the differences in experience among Spanish-speaking and English-speaking Hispanics. Further, researchers speculated that regional differences in the quality of experiences may be related to what resources are available in a state to meet the cultural and language needs of Hispanics.

O’Brien and Shea (2011) sought to examine patient satisfaction in settings that provide linguistically appropriate care. Their study was conducted in two healthcare clinics in Philadelphia that served a large majority Hispanic patient population and provided linguistically competent care. The CAHPS survey was administered to English and Spanish-speaking Hispanic patients and bilingual speaking patients (N= 1267) to examine whether language preference was a predictor of patient satisfaction. No significant subgroup differences in patient satisfaction were noted in overall care, timeliness of care or provider satisfaction. However, Spanish-speaking patients, when compared to English and bilingual speaking reported the highest level of satisfaction with access to care and the lowest level of satisfaction with provider-patient communication and helpfulness of staff ($p < 0.01$). The authors suggested that these subgroup differences may be related to varying levels of Spanish speaking ability of the staff, which was not measured.

Lastly, Devoe, Wallace and Fryer (2009) conducted a secondary data analysis of the 2002 Medical Expenditure Panel Survey (MEPS), which examined the perceptions of 16,700 patients about physicians’ communication and interpersonal skills. As in the 2010 NHDR, patients who had a visit with a healthcare provider in the past 12 months were asked to rate the frequency with which the following behaviors were exhibited by the physician provider.
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1) careful listening, 2) perceived respect 3) time spent with provider, and 4) understanding what was stated. Responses to these items were reported on a four-point scale (always, usually, sometimes and never). After controlling for socioeconomic and demographic factors, multivariate analyses revealed that Hispanics (OR 1.49; 95% CI 1.33 to 1.68), African Americans (OR, 2.01; 95% CI 1.33 to 3.05), males and those with a usual source of care (OR, 1.24; 95% CI 1.10 to 1.40) and public health insurance were more likely to report a positive interaction with the healthcare provider. In this particular study, level of education was not associated with patient satisfaction. Unlike earlier studies that suggested greater dissatisfaction with care among Hispanic Spanish speakers (Carrasquillo, Orav, Brennan & Burstin, 1999; Morales, et al., 1999), the findings of this study suggested that the Hispanic care experience can vary greatly. The contrasting findings suggested that there is much more to understand regarding perceptions of communication and care among Hispanics. These newer findings supported the hypothesis that individual patient values, experiences, level of acculturation, social support and infrastructure can influence patient satisfaction.

As one might expect, research findings suggested that appropriate interventions can improve patient satisfaction. In a quantitative study conducted in a San Francisco clinic, increased Spanish fluency among healthcare providers and provision of culturally sensitive care were associated with increased patient perceptions of patient empowerment (AOR, 3.13; 95% CI, 1.2 to 8.19) and perceived responsiveness to problems and concerns by physicians (AOR, 6.34; 95% CI, 2.1 to 19.3) (Fernandez, et al., 2004).

As previously stated, low income, lack of insurance coverage and poor education were identified as barriers to adequate healthcare (Coffman, et al., 2007). Nonetheless, research findings also suggested that ethnic and racial disparities still persist even when insurance coverage is present. An ethnographic study in which one-to-one interviews were conducted with 314 recently immigrated Mexican adolescents residing in Minnesota, two
overarching themes emerged. In contrast to Weech-Maldonado, Fongwa, Gutierrez and Hays (2008) and Devoe, Wallace and Fryer (2009), participants perceived care as difficult to obtain if English was not spoken. Conversely, care was perceived as better if the participant was allowed to communicate in Spanish (Garcia & Duckett, 2009). Furthermore, participants reported experiencing difficulty comprehending insurance procedures even when speaking the same language or seeking care from more than one clinic. Similarly, in a mixed method study conducted by Harari, Davis and Heisler (2008), participants associated lack of insurance coverage and language barriers with fear, insecurity and feelings of being inferior and unwelcome. In this study, 50 Hispanic immigrant participants in Michigan were interviewed to examine their perceptions of available healthcare resources. Fifty percent of the participants reported lack of insurance coverage as the primary barrier to accessing care because of fear related to costs. Seventy-two percent of the participants were uninsured and 94% did not know that they qualified on the basis of income for a free health insurance plan. Delaying treatment until someone who spoke English could attend an appointment was reported by 56% of the participants. Once treatment was received, 22% reported not understanding the treatment or diagnosis or left with unanswered questions. Lastly, social isolation was reported by 48% of the participants. Strategies developed by participants to navigate the healthcare system included using English speaking friends and family as interpreters, self-medicating or seeking medical care in country of origin. A small percentage of the participants (14%) knew to request interpreter services. The reliance on family or the social worker for support was also noted in a study conducted by Horwitz, Roberts and Warner (2008) who examined what occurred when Latina women with a stigmatizing illness attempted to seek care.

These findings were echoed in a qualitative study of 8 Spanish-speaking Latino nurses trained in their country of origin and living in Maryland conducted by Carter-Pokras et al.
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(2008). Their perspectives were considered important in understanding disparities in access to care, as these nurses were presumed to understand the complexities of the healthcare system and the needs of their community. Semi-structured in-depth interviews conducted in Spanish revealed many of the aforementioned barriers to care in addition to mistrust of the healthcare system and knowing fact from myth in disease symptoms and treatment. The participants recommended community outreach health education through media and the development of workshops. Hiring of bilingual staff and finding unique programs to bring in Latino health professionals were perceived to be solutions for addressing cultural and language barriers. Speaking Spanish to participants is perceived as a confidence builder and participants felt encouraged to articulate healthcare need (Garcia & Duckett, 2009).

The feelings of mistrust of the healthcare system exist and may stem from perceived discrimination. The perceived feelings of discrimination encountered by Hispanic patients in the American healthcare system were reflected in findings of two studies. In a quantitative study of 271 Hispanic immigrants in North Carolina, Keller et al. (2010) found that 55% of the population perceived discrimination. The increased likelihood of delaying treatment was associated with perceived discrimination based on race or ethnicity and insurance status (OR= 3.0, 95% CI: 1.4-6.2, 271, p <.05), or insurance status alone (OR= 2.7, 95% CI: 1.4-5.3, p < .05) or language barriers. However, perceived discrimination did not delay well visits (Keller, et al., 2010). These findings were supported by a study conducted by D’Anna, Ponce and Siegel (2010), in which the effect of perceived discrimination on patient emotional and physical health was examined in the 2001 California Health Interview Survey. In this quantitative survey, 55,428 participants were asked if they ever perceived discrimination and what were the perceived reasons, i.e., age, race, ethnicity, language, gender, and sexuality. The participants were non-Latino blacks, non-Latino Whites, Asian/Pacific Islanders and Latinos. Latinos constituted 21% of the sample. A large number of people in this sample
reported no physical health limitation (82%) and no emotional health limitations (80%).

Overall, five percent (N=2768) of the total sample reported experiencing some type of discrimination. Of the 5% that reported experiencing discrimination, 13% (N= 385) reported experiencing race, ethnicity or language discrimination. Specific data on the Latino participants revealed that 94.4% of the Latino participants sampled reported no perceived discrimination. However, the reported experience of racial, ethnic or language discrimination was highest among Latinos 1.8%, vs. non-Latino blacks 1.3% vs. multiracial “other” 1.4%.

Further, the reported experience of perceived discrimination for some other reason was 3.8% among Latinos.

Several important studies in community health and primary care settings were focused on understanding patients’ perspective on approaches to care and barriers. Garcés, Scarinci and Harrison (2006) utilized focus group methods to examine the health-seeking behaviors of 54 Latina immigrants who had been in the U.S. an average of 5.5 years. Negative behaviors such as fear of deportation and lack of time were identified as non-structural barriers to care. Positive behaviors, such as familial support, were noted to enhance care. Similar findings were noted in a study by Guo and Phillips (2006) in which 29 participants working and or residing in the same community were interviewed to identify barriers to accessing care for the elderly Mexican population residing in Arizona. Several infrastructural, cultural and socioeconomic issues were identified. Difficulty accessing transportation and lack of appropriate available resources were noted to be major infrastructural barriers. While, the patients’ inability to pay for healthcare, lack of health information, language discordance with practitioner, and cultural health practices that were incongruent with recommended health practices were noted to be social barriers.

The need for Hispanic patients and families to be participatory in care was also illustrated in a study by Crist, García-Smith and Phillips (2007). In this grounded theory
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study, 11 Mexican American elders and 23 caregivers from Arizona were interviewed in order to understand the disparity in utilization of elder care services in the home. The findings indicated that Mexican Americans who participated in this study preferred to utilize nursing care service in the home while maintaining the primary role of caregiver for the elderly patient. Three themes were noted in examining the process of services: 1) taking care of our own, 2) empowerment, and 3) acknowledging options.

It is important to note that the challenges facing many NEP or LEP Hispanic patients in the U.S. seeking healthcare in primary care settings are similar to patients with language barriers residing in other countries. Research findings suggested that patients from Southeast Asia residing in England experienced difficulty communicating with providers, which resulted in substandard care for patients (Gerrish, 2001; Gerrish et al., 2004). Similar patterns of interpreter utilization were reported in primary care and community health settings according to the findings of this study conducted by Gerrish et al. (2004). In this study, separate focus groups of nurses, community members from culturally and linguistically varied groups and interpreters were asked to discuss their perspective of interpreter services in a city north of England, serving five large ethnic patient populations. The nursing group consisted of district nurses as well as advanced practice nurses. For the nursing group, all interviews were conducted in English by two nurse researchers, who audiotaped and transcribed the sessions; transcripts of the interviews were then given to an independent interpreter to check for accuracy. Ethnic minority participants were recruited through community groups and interviewed by the researchers and a translator. Participants in the interpreter services focus groups varied in their interpretation skills and job descriptions. Nurses, patients and interpreters reported underutilization of face-to-face interpreter services, with a heavy reliance on family members to translate. When interpreter services were utilized, the preferred method for translation was bilingual coworkers. The preference for
bilingual coworkers was also noted in two studies that explored the experience of nurses using linguistic services in an acute care setting (Cioffi, 2003; Roberts, 1994).

Several studies suggested mixed results regarding patients’ feelings on the use of family members for interpretation. In some cultures where decisions are made as a family, patients may feel safer discussing embarrassing subject matters with family members over interpreters as noted in the Kuo and Fagan (1999) study. However, other patients feel using family members to be intrusive (Ngo-Metzger et al., 2003) and it may have a negative impact on the patient-provider relationship (Lee, Batal, Maselli, & Kutner, 2002).

Summary. All of the quantitative studies reviewed in this section reported sufficient sample sizes and utilized appropriate statistical methodologies. Equally, the qualitative studies described in detail the process of the data collection, process of reaching data saturation and data analysis. One of the limitations of the qualitative and mixed-method studies was that purposive samples of a specific population were used and despite reaching saturation, the findings cannot be generalized to broader Hispanic populations in different geographical regions (Gurman & Becker, 2007; Harari, Davis & Heisler, 2008; Heuer & Lausch, 2006; Tandon, et al., 2005). The findings of studies that segmented data by language and ethnicity suggested that the Hispanic patient experiences in the primary care setting as described in these studies are varied and depend greatly on geographic location, primary language spoken, ethnicity, resources, social support and socioeconomic status. Some Hispanics reported difficulty in seeking resources and navigating the healthcare system. Logistics, such as transportation and infrastructural barriers presented additional challenges. Study findings also suggested that Hispanics with language barriers experienced difficulty obtaining health insurance and accessing care was hampered by fear of deportation and perceived discrimination. Quantitative patient satisfaction studies suggested that once care was received, Spanish-speaking Hispanic patients when compared to English-speaking
Hispanics reported less satisfaction with the communication or interaction with the provider and timeliness with care (Devoe, Wallace & Fryer, 2009; Weech-Maldonado et al., 2007). Other findings from these studies suggested that when effective communication or cultural competence among healthcare providers was not present, patients with language barriers when compared to those without language barriers were less satisfied with their care, received substandard care, perceived being treated with disrespect and had difficulty accessing needed care (Keller et al., 2010; Harari, Davis, & Heisler, 2008; Tandon et al., 2005; Garcia & Duckett, 2007; Gurman & Becker, 2007; D’Anna, Ponce, & Siegel, 2010). Finally, O’Brien and Shea (2011) findings suggested that while an overall higher level of satisfaction with the quality of care was reported among English speaking Hispanics; the ability to speak the same language with the healthcare provider during a healthcare encounter alone did not predict level of satisfaction.

Exactly what behaviors exhibited by the provider caused satisfaction or dissatisfaction with regards to provider patient communication among patients, was for the most part unclear. For example, while the notion of respect may be a universal value, how respect was demonstrated varied across cultures. Additionally, there would be added value in knowing what behaviors exhibited by a provider were perceived by the patient to be careful listening, perceived discrimination or what is considered to be enough time spent by a patient.

Again, despite the importance of cultural competence, only 2 studies examined how providers operationalized cultural competence during the patient-provider interaction (Castro & Ruiz, 2007; Warda, 2000). What is clear from these studies is that the patient experience is enhanced when patients are allowed to participate in care or have the involvement of family members or support system. These studies were all conducted in the community setting to examine participants’ understanding of healthcare resources and their experience in accessing
those resources. These findings contribute to the ongoing dialogue on how to develop more culturally specific interventions to meet the healthcare needs of the population.

**Hispanics and perceptions of care in the Emergency Department.** Discussed in this section are the relevant findings from 6 quantitative studies conducted in the emergency department (ED) regarding patient perceptions of care and satisfaction (Bagchi et al., 2010; Carrasquillo, Orav, Brennan, & Burstin, 1999; Morales et al., 1999; Pytel, Fielden, Meyer, & Albert, 2009). Hispanic NEP or LEP patients seeking care in the ED have been the focus of researchers since many from this population use the ED as a primary source of care. Assessing patient satisfaction is considered important to study as it is theorized that satisfaction with care may be associated with follow-up care.

The results of a study conducted by Carrasquillo et al. (1999) supported this theory. Quality of care and patient satisfaction perceptions of Asian, African-American, White and Hispanic English speaking and non-English speaking patients were analyzed in this secondary data analysis study. Of the 2,333 participants, Hispanics represented 50% of the 354 non-English speaking participants. Separate data pertaining to NEP Hispanic patients were not reported. However, patients with language barriers were consistently more likely to report problems with communication (OR 1.47; 95% CI 0.96, 2.23), problems with diagnostic testing (OR 1.55, 95% CI 0.98, 2.46) and more overall problems (OR 2.36; 95% CI 1.30, 4.29). Non-English speaking patients when compared with English speaking patients, reported longer wait times, difficulty with discharge instructions, decreased perception of being treated with courtesy and respect and decreased completeness of care. It should be noted in this study, that overall satisfaction with care in the ED was reported to be low in both English and non-English speaking patients. Fourteen percent of non-English speakers as compared to 9.5% of English speakers were more likely to report that they were not likely to return to the same emergency department for treatment (p < .05).
To better understand the relationship between professional language interpretation and patient satisfaction among those with language barriers, Bagchi, et al. (2010) conducted a randomized control trial study in the EDs of 2 New Jersey hospitals. Participants were enrolled into 201 randomized 4 hour blocks of time into either treatment or control groups. The treatment group utilized on-site professionally trained interpreters available for interpretation, while the control group utilized telephonic interpretation and ad hoc interpreters available for interpretation. After the interaction, patients, physicians, triage nurses and discharge nurses were administered a quantitative study, using a Likert scale to assess satisfaction with care. Patient participants in both the treatment (N=242) and control group (N=205) were asked questions adapted from the CAHPS survey. Specifically, patients were asked to rate satisfaction with the communication with the provider and how well they understood what was stated to them by the hospital staff. Physicians, triage nurses and discharge nurses were asked whether the language barriers were adequately addressed in order to properly manage the patients’ condition. The results indicated that provide on-site interpreters significantly increased patients’ and providers’ satisfaction with communication. In the treatment group, patients who answered the satisfaction survey were very satisfied with the visit when compared with the patients in the control group (OR 72; 95% CI 31 to 167). In the treatment group, patients found it easier to understand the visit interactions when compared with the patients in the control group (OR 61; 95% CI 23 to 166). Additionally, the treatment group responses were clustered around the “very satisfied” and “mostly satisfied” categories with no responses in the “not at all satisfied” category, whereas, the control group responses were more varied. This led the authors to surmise that the variations in responses are seemingly related to the type of interpretation received. The authors reported that those who had a bilingual nurse or physician reported higher satisfaction with
communication and easier ability to understand when they communicated with a bilingual physician or nurse.

Pytel, et al. (2009) sought to understand if there was agreement between nurses and patients or visitors as to what communication items exhibited by the nurse are considered important during an ED visit. While this study did not focus on examining ethnicity or language perspectives, it is the first study to examine patients’ perceptions of nurses’ communication in the ED. Patients (n = 53), visitors (n = 70) and nurses (n = 73) were administered a quantitative survey and asked to prioritize a list of 19 communication items that they considered necessary for successful encounter with the nurse. The communication items included exhibited behaviors and posed questions. Two of the posed questions pertained to asking patients about their cultural and language needs. The results found that patients and nurses were matched on 8 of the top 10 communication behaviors perceived by patients as important for a successful encounter. Patients were then asked to rate the performance of the nurse on those same top 10 behaviors. This study revealed that patients perceived that nurses met their communication needs only 62% of the time. Only 26% of patients in this study considered the nurse asking about cultural needs as important.

Conversely, in another study, Jones (2008) found that nurses were concerned about how they communicated with their patients. In this qualitative phenomenological study, five nurses were asked to describe their experiences in caring for NEP Mexican American patients in an ED located in the Midwest. Through content analysis, three themes emerged: 1) continuity of care, 2) language barriers, and 3) limited cultural knowledge. Nurses expressed concern about the inability to develop relationships with patients and perceived that language barriers had an impact on all aspects of patient care. Nurses also had very basic understanding about the cultural needs of their patients.
The impact of language barriers on the utilization of services and treatment outcomes in the emergency department was the focus of 2 studies. In a comparative analysis study, Waxman and Levitt (2000) examined rates of admission and diagnostic testing in NEP and English-speaking patients in an inner city ED. In this sample of 324 patient participants, Hispanics accounted for 31% of the 172 NEP patients. The outcomes data for this study were not separated by language or ethnicity. The findings revealed that 5 diagnostic studies were ordered at a higher rate for NEP patients when compared to English-speaking patients among a group of patients with complaints of abdominal pain (CBC 18.4% [95% CI 5.1% to 31.7%]), serum electrolytes (17.9% [95% CI 3.8% to 31.9%]), urinalysis (20.0% [95% CI 4.5% to 35.6%]), ECG (23.4% [95% CI 8.6% to 38.2%]), and abdominal CT scan (10.9% [95% CI 1.0% to 20.8%]). The authors reported that there were no significant differences between English and non-English speaking participants in the group of patients with complaints of cardiac pain or in the overall rates of admission (5% [95% CI 10% to 20%]), length of stay in the ED (37.9 [95% CI –58.0 to 133.8 minutes]), or in the number of diagnostic tests ordered (no CI or p level reported). Ad hoc interpreters were used in 80% of the provider-patient interactions and it is unclear how the type of interpreter may have contributed to patient outcomes. Bernstein, et al. (2002) sought to explore the relationship between utilization of trained medical interpreters and patient management outcomes. In this study, 500 patient participants who received care in a Massachusetts teaching hospital were divided into 3 groups: English speaking (ESP) (N=63), non-English speaking with a trained medical interpreter (IP) (N=63) and non-English speaking without an interpreter (NIP) (N=374). Hispanics comprised 73%, 73% and 67% of the patient participant sample respectively. There were no significant differences in type of insurance coverage or presenting illness between the 3 groups. Unlike the Waxman and Levitt study, findings from this study suggested that NEP patients when compared to English proficient patients received fewer
diagnostic testing ($p< 0.05$), had a shorter duration in the ED by 3 hours ($p< 0.05$) and received fewer medications ($p< 0.05$). A 30 day follow-up also revealed significant differences. Interestingly, IPs were more likely than ESPs and NIPs to be given follow-up clinic visits ($p< 0.05$). However, while IPs were more likely than NIPs to attend clinic visits, they were still less likely than ESPs to attend clinic visits ($p< 0.05$). Findings from this study demonstrated that a disparity in services exists between language groups with the greatest disparity noted between English speakers and those limited English speakers who utilized ad hoc interpreters. This suggests that language barriers and the quality of interpretation can affect care, but to what extent is unclear. Lastly, Sarver and Barker (2000) found differences in follow-up care in patients with language barriers when compared to patients without language barriers after an emergency department visit. Those with language barriers were significantly less likely to receive appointments for follow-up care after being seen in the ED ($p = .05$). However, among those who received a follow-up appointment, results suggested that there was no significant difference noted in compliance among Spanish-speaking patients with various levels of English proficiency ($p = .78$). Perhaps as suggested by the authors that the discharge instructions were offered in Spanish by the nurses.

**Summary.** All of the studies discussed in this section were approved by IRBs. The quantitative and qualitative studies both described rigorous methodologies. For the qualitative study researchers reported data saturation as the determinant of sample size. The patient samples in these studies included individuals from several different ethnicities who spoke several different languages with Asians and Hispanics samples being the largest ethnic groups. English and Spanish were the most commonly spoken languages. Two weaknesses noted in all the studies were that language fluency was determined by participants’ self-report and health literacy was not assessed in any of the studies. In all of the quantitative studies, participants used the language of their choosing.
The majority of the research literature on the Hispanic healthcare experience in the ED is focused on examining the impact of language on various aspects of care while only 2 studies examined the role of cultural competency on the quality of care. For many patients, the ED is considered to be the primary source of care. Findings suggested that the NEP or LEP Hispanic patient experience was correlated with the patient-provider interaction, the quality of interpreters and timeliness of care. The indicator most frequently used to examine the patient experience in the ED was patient satisfaction with provider communication. In terms of quality of care, study results indicated a mixed picture. Those with language barriers were noted to have fewer or excessively more diagnostic tests ordered, received fewer follow-up appointments and stayed in the ED for fewer hours when compared to those with language barriers. However, the findings revealed that NEP or LEP patients perceived that satisfaction with care and health outcomes improved when the appropriate linguistic interventions were in place. Nevertheless, providers continued to utilize ad hoc interpreters due to reported time constraints, lack of institutional support and convenience of bilingual workers.
**Inpatient Hospitalization.** There were 11 reviewed research articles regarding inpatient hospitalization in the U.S. Ten of these studies used quantitative methodology and one qualitative study. The populations of interest in these studies were generally disease specific or those receiving care in the intensive care units. Patients with language barriers and in particular Hispanic patients with language barriers and their experiences were addressed in these studies, but from limited but varied perspectives: quality of care (Anders et al., 2010; Borders, Lensing & Xu, 2011; Britton, 2006; Clever, Jin, Levinson, & Meltzer, 2008; Jha, Orav, Zheng & Epstein, 2008; McNeill, Sherwood, Starck, & Nieto, 2001; Williams, 2004) and use of culturally and linguistically appropriate services (Joint Commission, 2010; Schenker, Perez-Stable, Nickleach, & Karliner, 2010).

Generally speaking, capturing what happens during hospitalization requires consideration of many confounding variables that affect the perceived quality of the inpatient experience (Borders, Lensing, & Xu, 2011; Britton, 2006; Williams, 2004; McNeill et al., 2001). For example, Britton (2006) conducted a quantitative study that examined the overall satisfaction with care in 300 perinatal women prior to discharge and again at 30 days post discharge. Study findings revealed that women with low, moderate and severe levels of anxiety reported decreased levels of satisfaction when compared to women without anxiety ($p = .000$ to $.005$). In those with depression, more mothers reported negative perceptions of quality of care during hospitalization when compared to those without depression (60.9% vs. 42.3%), but the difference did not reach statistical significance ($p=.066$). Additionally, positive patient satisfaction ratings decreased over time and there was no statistically significant difference in levels of satisfaction between mothers who were very satisfied and mothers who were less satisfied during hospitalization. The researchers did not note any significant differences in patient satisfaction by socioeconomic class or ethnicity. Britton
suggested that these findings indicated that patient perceptions were influenced by time as well as complexities of illness.

The Centers for Medicare and Medicaid (CMS) and DHHS developed the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) as part of a larger initiative to improve quality of care in hospitals by informing the public about the performance of hospitals in the U.S. The HCAHPS provides a standard tool to measure patients’ perspectives of hospital care. This survey includes items on the hospital environment, nursing and physician communication, pain control and patient education (CMS, 2010). Through an interactive website, the public is able to access survey results and compare performance indicators of area hospitals.

Patient satisfaction based on study findings utilizing data from the 2005 Medical Expenditure Panel Survey, Borders, Lensing and Xu (2011) asserted that confounding variables may contribute to patient satisfaction. Patients who had higher levels of health confidence, that is, believed they could take care of their own health matters, reported lower levels of patient satisfaction. At the national level, 80% of patients reported that physicians “communicated well” as opposed to 74% of patients who reported that nurses “communicated well”. Only 59% of patients reported that they received medication education, 68% reported adequate pain control and 80% reported receiving discharge information. A linear regression model was used to control patient characteristics that may affect patient reports of hospital experiences (CMS, 2010). These survey findings suggested that during hospitalization, patients and nurses are not engaged in safe and effective communication. The April 2008-March 2009 HCAHPS survey results for all five hospitals in Montgomery County, Maryland, indicated that 75% of patients perceived that physicians “communicated well”, in contrast to 64% of patients who reported that nurses “communicated well”. Only 50% of patients reported that they received medication
education, 62% reported adequate pain control and 78% reported receiving discharge information. These survey results were lower than both the state and national averages for the same categories. The study of interpreter utilization among 234 LEP hospitalized patients found that interpreters were underutilized during hospitalization overall, but were used at higher rates during physician encounters than during nursing encounters [60% vs. 37%, respectively] (Schenker, et al., 2010). Lastly, similar to the studies previously conducted outside of the U.S., patients viewed the ability to socially engage in their primary language while in the hospital as comforting (Johnson, et al., 1999; Warda, 2000) and as enhancing their care (Irvine et al., 2006; Tocher & Larson, 1999).
Hispanics and Hospitalization. Specific to minority health and hospitalization in the U.S., several trends were noted. Muennig, Jia, Khan, and Pallin (2006) found that immigrant patients residing in New York City had fewer hospitalizations when compared to the native born U.S. resident population in the study and hypothesized that the lower incidence of hospitalizations may be due to overall better health of immigrants compared to the health of native born U.S. citizens. However, Hispanic and African patients from the Sub Sahara region of Africa were noted to have higher hospitalization rates when compared to native born citizens. In other studies conducted in various regions of the U.S., it was noted that Hispanics received standard inpatient care but received discharge instructions at lower rates (Chandra, Clark, & Camargo, 2009), have higher readmission rates (Ash & Brandt, 2006), and are less likely to be discharged to outpatient rehabilitation following hospitalization (Nguyen-Oghalai et al., 2009) when compared to Whites. Language barriers were mentioned only in one study (Chandra et al., 2009) as a possible explanation for the disparities. Patient safety was noted to be compromised with patients with language barriers. Quan (2010) conducted a quantitative study that examined the malpractice claims paid by an insurance carrier in which language barriers were involved. Examination of 35 claims found 4 common errors: 1) failure to provide competent interpreters, 2) failure to provide written translation of documents to patients in their preferred language, 3) lack of proper documentation of language barriers and, 4) allegations of discrimination.

Conversely, in examining pain management outcomes in 102 Hispanics in a southwest hospital, McNeill et al., (2001) noted that 77% of the participants reported high patient satisfaction scores despite having high pain scores. The researchers of this mixed method study reported that these findings were similar to a pain outcome study previously conducted in non-Hispanic Whites (McNeill et al., 2001). The qualitative findings of this study suggested that patients reported satisfaction due to receiving pain medication when
asked and in a timely fashion. More importantly, the authors posited that the employment of Hispanic nurses in addition to the patients’ ability to speak English may have negated some of the cultural and language barriers seen in less acculturated Hispanic populations. These findings are similar to those of the study of Anders, et al. (2010), a retrospective study in which 18 inpatient quality indicators developed by the AHRQ were measured by reviewing 19,187 medical records in a Texas hospital that primarily serves an underserved Hispanic population. The 18 indicators measured 5 key areas: 1) mortality rates for medical conditions, 2) mortality rate for surgical procedures, 3) hospital-level procedure utilization rates, 4) area-level utilization rates, and 5) volume of procedures. When compared to non-Hispanic Whites, Hispanics were noted to have better than expected rates on 17 of the 18 indicators. However, the researchers reported that 70% of the registered nurses and 80% of the ancillary staff spoke Spanish, the nurse-patient ratio was 1 to 4, and 70% of the registered nurses had a baccalaureate degree; McNeill et al. suggested that these variables may contribute to the health outcomes of this population.

These findings are in sharp contrast to the following study. The characteristics of hospitals providing care for the majority of Hispanic elderly patients residing in the U.S. were examined. Data from the 2004-2005 Medicare Part A files and other national hospital quality indicators were examined (Jha, Orav, Zheng & Epstein, 2008). The results revealed that hospitals with a high proportion of elderly Hispanic patients when compared to hospitals with a low percentage of elderly Hispanics were more likely to be medium-sized hospitals located in urban areas. They were also more likely to be classified as ‘for profit’ agencies and have a high percentage of Medicaid patients. A disparity in quality of care was also noted to be significant. Hospitals with a higher proportion of Hispanic elderly were noted to have higher nurse-patient ratios and be less likely to have cardiac or medical intensive care units. Further,
performance scores on quality indicators were generally lower for hospitals that admitted a higher proportion of Hispanics when compared to low proportion hospitals.

Hicks, Tovar, Orav and Johnson (2008) sought to understand what factors may influence racial and ethnic disparities in patient satisfaction among inpatients in a Massachusetts hospital. In this qualitative study, 37 African American and Hispanic male and female patients who had a recent hospitalization on a medical or obstetric unit participated in focus groups. Structured questions were asked to elicit participants’ positive and negative experiences on 7 processes of care developed by the Picker Institute (Hicks et al., 2008). Patients were asked to speak about their experiences in the following domains: 1) respect for patient preferences, 2) coordination of care, 3) information and education, 4) physical comfort, 5) emotional support, 6) involvement of family and friends, and 7) continuity and transition of care. For Hispanic patient participants, the presence of interpreters or Hispanic nurses was noted to improve care and result in positive experiences. Hispanic patients reported positive experiences when family and friends were involved in care, when physicians and nurses made time to ask about feelings and opinions, having consistent staff, being able to talk to the social worker or a chaplain, and receiving education throughout the hospitalization and at discharge. Negative experiences were noted when the aforementioned did not occur and when pain was not controlled. Hispanic women also reported feeling pressured to make a surgical decision to be a negative experience. This study is one of the few qualitative studies conducted in the U.S. that examined perceptions of care of non-Hispanic speaking patients. Additionally, this study did not fully illuminate what behaviors or expectations of the non-Hispanic speaking healthcare provider the patient perceives to be important in providing quality care. Nor, did it reveal how the illness of the patient influenced perception of care. However, it elucidated the importance of communication and relationships for Hispanic patients.
The cultural values of the family were noted in the results of the 1999 Professional Support Questionnaire (PSQ) for Critical Care Nurses Working with Family Members (Waters, 1999). The PSQ was used in this study to examine cultural differences in professional nursing support expected by family members. The questionnaire items were developed from family statements from a previous 1993 ethnographic study conducted by Waters. Using a 4-point scale of 1 (strongly disagree), 2 (disagree), 3 (agree), or 4 (strongly agree), 90 family members were asked to rate 36 interventions provided by critical care nurses that the family members considered to be supportive. Family members were representative of three cultural/ethnic groups: Hispanic, African-American and Whites. Subgroup variation data were not addressed. The prompt was “the critical care nurse can best support me by . . . .” While there was not a statistically significant difference across the total mean of each cultural group ($p = .84$), significant differences were present across cultural groups on individual items: 1) “Being concerned about my comfort in the waiting room” ($p = .007$), 2) “Reassuring me that my family member is stable enough that I can leave the waiting area and/or hospital for a while” ($p = .001$), 3) “Telling me about chaplain services” ($p = .024$), 4) “Visiting the waiting room at least once a shift to check out the concerns of family members” ($p = .007$), 5) “Providing an interpreter for non-English speaking family members” ($p = .019$), 6) “Telling me about the hospital and critical care telephones” ($p = .017$) and, 7) “Telling me about the family support groups” ($p = .006$).

Post hoc comparisons of mean scores found that Hispanic family members differed significantly with White family members on “Visiting the waiting room at least once a shift to check out the concerns of family members” (3.10 vs. 2.63); “Providing an interpreter for non-English speaking family members” (3.47 vs. 3.00); and “Telling me about the hospital and critical care telephones” (3.07 vs. 2.70). Post hoc comparisons found that Hispanic family members differed significantly with African-American family members on “Being
Lived Experience NEP LEP Hospitalized Patient

cconcerned about my comfort in the waiting room” (2.63 vs. 3.07); “Reassuring me that my family member is stable enough that I can leave the waiting area and/or hospital for a while” (3.17 vs. 2.63), and “Telling me about the family support groups”, (2.33 vs. 2.83).

To address cultural needs, The Joint Commission (2010), conducted a study to establish a baseline of the culturally and linguistically appropriate services provided in hospitals in 3 neighboring Florida counties. Purposive sampling was used to select fourteen hospitals in Florida’s Palm Beach, St. Lucie, and Martin counties. These counties were selected because of their large diverse immigrant populations. Data were collected via two surveys. Hospital staff were queried on their utilization of culturally and linguistically appropriate services. In this sample of 608 respondents, 47% were nurses, 4.7% were physicians with the remaining pool consisting of ancillary support service personnel. The researchers reported that despite the availability of culturally and linguistically appropriate services at the local and national level, there was a disparate availability and utilization of culturally and linguistically appropriate services across these county hospitals. Furthermore, institutional barriers such as time constraints, lack of knowledge among staff regarding available resources, weak or nonexistent processes or policies regarding the use of interpreters, and lack of evaluation of bilingual staff fluency and lack of implementation of language programs were identified. The findings of this study echo a similar qualitative study conducted by Davidson, Boyer, Casey, Matzel and Walden (2008) in which 22 religious experts and community members from 12 different ethnic and religious groups participated in a panel discussion and semi-structured interviews to explore the available religious and cultural resources and the cultural knowledge of medical and nursing staff at a California hospital. What was revealed is that while some interventions have been implemented to meet the needs of a diverse patient population, the cultural needs of patients and family members were largely unmet. The authors reported that while similar themes
emerged from the participants, data saturation was not achieved since only 2 people from each subgroup participated.

**Perceptions of care among patients with language barriers outside of the U.S.**

In this section ten quantitative, 2 qualitative studies and 1 mixed method study were reviewed. These studies were conducted outside the U.S. in varied patient populations (Bischoff, Perneger, Bovier, Loutan, & Stalder, 2003; Brooks, et al., 2000; Cioffi, 2003; Fatahi, Mattsson, Hasanpoor, & Skott, 2005; Gerrish et al., 2004; Roberts, 1994; Thompson, 2001; Irvine et al., 2006). Five studies (1 quantitative, 2 qualitative and 1 mixed method) conducted outside of the U.S. explored the impact of cultural and language barriers on patient care and communication from the patients’ and or nurses’ perspective during hospitalization (Brooks et al., 2000; Cioffi, 2006; Eckhardt, Mott, and Andrew, 2006; Thompson, 2001; Roberts, 1994).

Roberts (1994) conducted an ethnographic study in Wales examining the linguistic ability and interactions between bilingual nurses and patients in a healthcare setting where English and Welsh were spoken. Using several sociolinguistic theories as a conceptual framework, Roberts observed patient-nurse encounters over a 15-week period, as well as, conducted formal and informal interviews. What emerged from this study was what Roberts referred to as language switching. In language switching, bilingual participants engage in conversation using both languages and interchange language spoken throughout the encounter depending on the situation. Language switching was noted to occur during specific instances of the conversation. Initially, it occurred in the beginning of the conversation to establish a language base. Switching was noted to either include or exclude a third party individual. In this instance, two individuals would either accommodate a third person by switching to a common language or continue to exclude the individual. Finally, language switching was observed to occur when patients wanted to be very expressive or have a
feeling of comfort. The findings from this study suggested that patients’ ability to communicate with the nurse directly enhanced the nurse-patient relationship. Further research in a descriptive study conducted in England by Brooks et al (2000) focused on patients’ perspectives of interpreters in the hospital. In this study, 277 patients who spoke either Punjabi or Urdu as their primary language were interviewed regarding their experiences with interpreters. Sixty-six percent of the patients were either NEP or LEP. The percentage of those who actually used an interpreter was not reported. However, 89% of those who used an interpreter considered them to be “useful”. The reason most often cited for requiring an interpreter was for explaining and understanding of medical treatments and course of hospitalization. Forty-eight percent of patients reported not having an interpreter when needed. Of these patients, communication with medical team was frequently cited as the reason for requiring the interpreter. In those who had an interpreter and in those who did not have an interpreter, wanting an interpreter to engage in social interaction was noted. Not all patients viewed interpreters positively. Eleven percent of patients cited personality conflicts with the interpreter and 25% wanted family or friends to interpret due to distrust of the interpreter. The issue of distrust was also noted in a study by Cioffi (2003), where nurses and patients raised the issue of confidentiality and expressed concern that the interpreter would divulge health information to members of the patient’s community.

Cioffi (2006) used interpretive methodology to explore the nurse-patient interaction from the perspectives of 4 nurse-patient dyads from different backgrounds regarding their interactions during an inpatient hospitalization in Australia. Patient participants were asked to describe their perceptions of the care received from the nurse. Nurse participants were asked to describe how they were providing care for the patient. Three themes emerged from the analysis of the data: held awareness, perceived difference and shared tensions. Patients and nurses shared the same perception regarding cultural differences. Both patients and
nurses reported shared perceptions regarding language differences. Patients and nurses reported concerns about obtaining accurate information and the need for interpreters. Finally, shared tensions were described by both patients and providers regarding the presence of family at the bedside. The author noted that the cultural and language differences reduced the nurse-patient relationship to the lowest level of interaction.

A phenomenological study by Eckhardt, et al. (2006) was conducted in Australia. This is one of two studies to date that has utilized qualitative methods to explore experiences of non-English speaking patients after a hospitalization. Using semi-structured interviews, the researchers asked six German speaking women about their inpatient experience. The three themes that emerged from the data analysis were described as ‘nursing for the masses’, ‘nursing the individual’, and communication and language. Participants also spoke of decreased trust of the nursing staff, fear and anxiety of the unknown and the need for nurses to address the language needs of non-English speaking patients. These findings support previous research regarding those with language barriers experienced by patients who may find it difficult to effectively communicate when under stress (Kim, 2000).

Discussion

This literature review reveals a complex, yet not fully developed picture of the Hispanic healthcare experience. To start, the Hispanic population consists of several subgroups that originate from several countries. But socioeconomic and cultural variations also exist and how these factors affect the healthcare experience is not fully understood. According to the current body of health research literature, language fluency, education level, healthcare literacy and socioeconomic and cultural factors contribute to health and healthcare disparities among Hispanics residing in the U.S. Many studies suggested that provider-patient communication, bias and cultural competence were primary factors that affected
healthcare outcomes among minority populations in the U.S. (AHRQ, 2010; Flores et al., 2003; Gardner & James, 2006; Gaston-Johansson et al., 2007; Sarver & Baker, 2000; Smedley et al., 2002). The impact of these socioeconomic and cultural factors on the healthcare experiences of patients has been examined extensively in community health, and somewhat in emergency departments. There is limited research examining the experiences of NEP or LEP Hispanics in inpatient settings. The concepts most frequently researched in outpatient and ED settings were communication barriers, patient safety and patient satisfaction.

There are barriers in which Hispanic patients, particularly those who are NEP or LEP, face that are specific to the healthcare setting. Community health and primary care patients report concerns about having transportation to appointments, or how to navigate insurance issues or difficulty in arranging someone to interpret during visits when needed. Patients who visited the ED face inefficiencies in care or poor follow-up. Patients in the hospital setting have reported difficulty in being treated as decision makers in their own care, discrimination and increased feelings of isolation (Elderkin-Thompson et al., 2001; Irvine et al., 2006; Narayanasamy, 2003; Preloran, Browner, & Lieber, 2005). For Hispanic patients in the U.S., particularly individuals who have limited proficiency in English, these fears and stressors can also limit their ability to communicate effectively.

Research examining the hospital experience and the concept of patient satisfaction in the hospitalized patient is receiving increased attention as researchers and governmental agencies are focusing on the hospital experience and quality of care. Findings suggest that variables such as depression, course of illness and other variables such as cultural values and health-related self-efficacy behaviors can influence satisfaction with the healthcare encounter as well as the hospital experience. Not surprisingly, several studies have demonstrated differences in patient satisfaction among Hispanics across geographic locations. Although
Cultural Competency programs and patient-centered care are nationwide initiatives of independent and governmental agencies; implementation of these services is inconsistently applied across institutions in the U.S. healthcare system.

The research on language interpreters in the healthcare setting has provided insight into some of the perceived benefits and challenges that healthcare providers and patients experience. Key research findings from these studies suggested that both healthcare providers and patients experienced difficulty because of their inability to effectively communicate during the healthcare encounter. Some healthcare providers have reported experiencing frustration about time constraints, patient confidentiality and patient safety when engaging in a health encounter with communication barriers; while some patients reported experiencing concerns about quality of care; perceived discrimination and decreased satisfaction with encounter (Mayo et al., 2007). Conversely, some Hispanic patients report greater satisfaction when providers spend time or express interest in the patient.

Use of interpreters is seen as an effective way to communicate during an encounter with language barriers. However, several issues were reported consistently across studies as barriers to effective communication with use of interpreters: 1) utilizing ad hoc interpreters, those who are not certified or qualified provide language interpretation, 2) the inconvenience of having to wait for the interpreter, 3) the lack of trust of interpreters by patient and provider, and 4) concern by providers about the impact of interpreters on the provider-patient relationship. As was suggested in the findings of several of the studies reviewed, successful interpretation occurred when the provider and interpreter were able to communicate and collaborate with each other effectively (Elderkin-Thompson et al., 2001; Lee, et al., 2005). Results from these studies suggested that regardless of setting, the patient-interpreter-provider is a triad involved in a complex and dynamic communication process. When an interpreter was involved, the dynamics of the patient-provider relationship changed; the
interpreter became the liaison between the provider and patient. It was the impact of interpreters on the relationship between patient and provider that emerged as a concern to providers in the discussion of the findings in several studies.

Across several studies, there was an association between the individual cultural beliefs of healthcare providers and their utilization of linguistic services. Those providers whose cultural beliefs were more ethno-centric practiced under the paradigm of patients being responsible for their own language needs. These practitioners were less likely to engage in culturally and linguistically appropriate practices. This was demonstrated through the use of family members to interpret or the reluctance to arrange interpreter services (Cioffi, 2003; Irvine et al., 2006; RWJF, 2004; Warda, 2000). In contrast, those healthcare providers who engaged in culturally and linguistically aware activities examined their own biases and expressed greater empathy toward their patients (Gonzalez-Espada, et al., 2006; Fernandez, et al., 2004; Warda, 2000). Although the patient populations in these studies varied in both language and culture, the issues regarding language barriers and utilization of translation services were very similar across cultural groups and countries.

These studies have provided some useful but limited insight into the Hispanic healthcare experience. For example, the findings from the quantitative patient satisfaction studies have suggested that patient satisfaction can vary across geographic locations, between cultural groups and levels of English fluency, thereby suggesting that it is influenced by individual and cultural values. While the measured behavior variables in the CAHPS and MEPS tools provided useful insight, they were not evaluated for cultural significance.

In the U.S., there has been little attention given to the perceptions of the Hispanic non-English or limited English speaking persons related to an inpatient hospitalization experience. This is an important issue to address as patients with language barriers are
vulnerable and the individual level support that may be experienced in community settings may not be present in the hospital (Eckhardt et al., 2006; Hicks et al., 2008; Roberts, 1994). Furthermore, in order to close the disparity gap in quality of care, it is essential to examine the healthcare needs of patients at all healthcare settings.

Unlike Hicks et al. (2008) and Eckhardt et al. (2006) in which semi-structured interviews were conducted to examine the experiences of patients with language barriers during a hospitalization; this author conducted phenomenological unstructured interviews. This allowed the patient to discuss his or her hospital experience in a more in-depth fashion, which allowed for rich data. In Chapter III, the methodology, setting, ethical considerations data collection and data analysis are discussed.
Chapter III: Methods

Introduction

The purpose of this phenomenological study was to describe the lived experiences of non-English speaking and limited English speaking Hispanic patients who have had a hospitalization in an acute care setting in the United States (U.S.). This chapter provides the details of the historical and intellectual underpinnings of the philosophy of existential phenomenology and description of hermeneutic methodology which informs the research design. Lastly, the particulars of the research design itself are described: 1) objectives, 2) sampling methods, 3) inclusion and exclusion criteria, 4) strategies to ensure trustworthiness, 6) data analysis, and 7) protection of human subjects.

Background

Phenomenology- Philosophy

The philosophy of existential phenomenology as developed by Merleau-Ponty guided this study. Phenomenology is the study of phenomena through the lived experience. The development of phenomenology was influenced by the German and French philosophical movements in the early 19th century. The German phase was introduced by Edmund Husserl. The French phase was influenced by Maurice Merleau-Ponty, Gabriel Marcel and Jean Paul Sartre (Spiegelberg, 1954). The following discussions trace the historical roots of these philosophies.
**German phase.** The underpinning of phenomenology began in Germany with the work of Edmund Husserl and a small group of philosophy students (Cohen, 2000; Laverty, 2003; Speziale & Carpenter, 2007; Spiegelberg, 1983). This period known as the German Phase, started as a small and intimate group of phenomenology students and quickly evolved to a larger group that had become splintered by the influences of world events, namely World War I and World War II (Spiegelberg, 1983). During this phase, Edmund Husserl developed what is known as descriptive phenomenology. In this early stage of phenomenology, a human being was no longer considered an object of psychological or physical parts, but a being in the world (Merleau-Ponty, 1958/2004). This being is connected to the world and others through intentionality which is the understanding that the consciousness is always aware of something in the world (Cohen, 2000). Despite, the connection with the world, Husserl believed that a being could be studied and understood at its essence.

To arrive at this level of understanding, one needs to block out interference from the outside world. Husserl introduced the concept of bracketing, the process of setting aside thoughts and suppositions to get to the essence of the phenomenon (Laverty, 2003). Martin Heidegger, a former student of Husserl, added the assumption that the human consciousness and perceptions are formed by historical and social contextual experiences (Laverty, 2003). In other words, one is constructed by the world while one is helping construct the world through one’s background and experience. Through this exchange, a level of interpretation occurs as each shapes the other and the interpretation is influenced by the individual’s history and background (Laverty, 2003). Heidegger’s philosophical tenets have formed what is now known as hermeneutic phenomenology and the foundation for the work of the French philosophers.
French Phase. The next significant phase of the phenomenological movement was the French phase and included the philosophical works of Maurice Merleau-Ponty, Gabriel Marcel and Jean Paul Sartre, whose work was known as French existentialism (Speigelberg, 1954). During this period, there was overlap between hermeneutic and existential movements and many of the phenomenologists are named in both movements (Munhall, 2007). As existential phenomenologists, all three philosophers dialogued about the human existence as it relates to others, space, time and body.

Although Marcel, Sartre and Merleau-Ponty are considered existentialists, their works are quite different. The philosophical ideologies formed during this period were shaped by each of the philosophers’ own historical and cultural context. Marcel’s work focused on being in the world and the relationship with God (Marcel, 1964/2002). The effects of World War II and personal explorations with Marxism and Communism influenced Merleau-Ponty’s and Sartre’s divergent philosophical thoughts on freedom, perception, embodiment and speech (Speigelberg, 1954; Stewart, 1998; Thomas & Pollio, 2002). The most fundamental differences in Sartre’s and Merleau-Ponty’s approaches are their philosophies on the role of the consciousness in how one perceives the world (Stewart, 1998). Moreland (1998) described the differences in philosophy as a “…disagreement over opacity and transparency of consciousness” (pg. 23). According to Moreland, Sartre viewed the consciousness as transparent, present and forefront in all behaviors and perceptions; therefore, an individual could never err in what was perceived in the world. Merleau-Ponty, on the other hand, viewed the awareness of the consciousness as less present in our actions and perceptions and requires reflection in order to understand what was perceived. Additionally, Merleau-Ponty sought to understand human behavior within the context of the environment and “chose perception as primary to the task of describing the human experience of human life” (Thomas & Pollio, 2002, pg. 13).
Thomas (2005) argued that Merleau-Ponty’s philosophical approach to phenomenology is congruent with nursing practice and with nursing research. Typically in clinical practice, the patient and the nurse meet and engage in a relationship centered on the care of the patient. Both the nurse and the patient perceive and dialogue with one another based on their own historical and cultural context and preconceived biases. In order to develop a collaborative plan of care for the patient, the nurse is educated to set aside biases and to, consider the patient in his or her entirety and as the expert of self. Similarly, phenomenological research requires the researcher to inquire about a phenomenon by listening and dialoguing with others to describe the being in phenomenon. Munhall (2007) noted that in order to gain understanding from this dialogue and listening, it is essential for the researcher to participate in the process of “becoming phenomenological” (pg. 219), through bracketing.
Bracketing. The concept of bracketing in phenomenology originated with Husserl and was intended to have the researcher set aside presuppositions, personal bias, and suppositions in a formal and structured manner in order to get to the essence of the phenomenon (Laverty, 2003; Spiegelberg, 1960). Some phenomenological researchers have argued that bracketing is not an appropriate methodology for existential and hermeneutic phenomenological approaches (LeVasseur, 2003; Thomas, 2000). As noted by Laverty (2003), existential and hermeneutic phenomenology does not expect the researcher to set aside or bracket biases and assumptions, but rather to self-reflect throughout the research process and be explicit in stating how the experiences of the researcher relate to the research topic. Merleau-Ponty (1958/2004) noted, “Analytical reflection starts from our experience of the world and goes back to the subject as to a condition of possibility distinct from that experience, revealing the all-embracing synthesis as that without which there would be no world” (Merleau-Ponty, 1958/2004, p.x).

The disagreement with the intent of bracketing lies in the interpretation of the Husserlian definition of bracketing as a complete suspension and separation of self from the world. This interpretation is in direct contrast with the tenets of self-reflection and intentionality that are consistent with hermeneutic phenomenology. However, several phenomenological researchers proffered a different perspective. Thomas (2000) asserted that Husserl never stated that the suspension was permanent or that one could be completely unbiased. Thomas (2000) further asserted that the suspension of biases and presuppositions is temporary and can return to the awareness of the researcher, and an interpretation of bracketing that requires self-reflection and examination throughout the study is consistent with the hermeneutic tradition. LeVasseur (2003) like Thomas (2000) also interpreted Husserl’s notion of bracketing as temporary. However, LeVasseur (2003) extended the definition of bracketing from an extension of the natural attitude, that is, a suspension of our
daily knowledge and lack of curiosity of the world to a reflective “persistent curiosity” that allows us to be open to receiving new knowledge. Maso (2007) noted that bracketing allows the researcher to be open to the retelling of the participants’ experience, as if the researcher is experiencing the event.

In keeping with the tradition of Merleau-Ponty, George and Thomas (2010) and Thomas and Pollio (2002) suggested that bracketing should occur through a process known as the bracketing interview. Participating in the interviews will allow the researcher to reflect upon his/her personal knowledge and lived experience of the phenomenon under study (Thomas, 2000). “This is designed to heighten awareness of any preconceptions or biases arising from personal experiences and minimizes the potential for distortion of during data collection and analysis” (George & Thomas, 2010 pg.1094).

To that end, the researcher, bilingual research assistants in this study participated in bracketing interviews. The researcher conducted bracketing interviews of the bilingual research assistants. The researcher documented thoughts, assumptions and biases prior to the start of the interviews. Additionally, the researcher consulted with a doctorally prepared nurse researcher experienced with the interpretive process throughout the study (Thomas & Pollio, 2002). Further, after every participant interview, the researcher and assistant/interpreters reflected and debriefed on the interviews. All of the reflections were documented and maintained in the researcher’s journal.

**Hermeneutic Phenomenology-Methodology**

Qualitative methods involve inductive processes that allow themes to emerge from the voices of the participants (Creswell, 2009; Marshall & Rossman, 2011; Cohen, Kahn & Steeves, 2000; Morse & Field, 1995). An underlying assumption of hermeneutic phenomenology as a method and a philosophy is that it is considered to be interpretive in
nature. In hermeneutical phenomenology, the participant is considered the expert and the researcher facilitates the process of open inquiry in an interpretative reiterative fashion until the essences of meanings are revealed (Esposito, 2001; Maso, 2007; Thomas & Pollio, 2002). Hermeneutical phenomenology views the participant and researcher as essential components of an interpretive process interacting to describe the meanings of a phenomenon (Creswell, 2009; Bender, Harbour, Thorp & Morris, 2001; Esposito, 2001; Marshall & Rossman, 2011). The participant’s interpretation was based in that individual’s life tradition and past experiences (Cohen, Kahn & Steeves, 2000). This was key, as this method acknowledged that a participant’s current experience was influenced by past experiences and there was constant interaction between the individual and the world (Marshall & Rossman, 2011). In order to gain a deeper understanding of the phenomenon, it is important to explore it within the world context.

The hermeneutical approach was especially fitting for this study. It facilitated the exploration of phenomena experienced by an at-risk and underserved population whose voice was limited in the health care system. The method provided the opportunity for the individuals to recount their health care experiences without isolating their life history. This lent itself to a deeper exploration and understanding of participants’ perceptions of their hospitalization experience.
Assumptions. The following assumptions laid out by Merleau-Ponty (1958/2004) guided this study: 1) perception shapes all individuals and their connection with the world, 2) the individual and the world are always in interaction with the other, 3) the human body is both the subject and the object in the life world, 4) all experiences should be studied in occurrence of everyday life, 5) the experience of life is perceived through the body and senses, 6) culture, language and social context shape the individual experiences, and 7) behavior and experience are interrelated functions of life and, therefore, a first-person description of an existence can be obtained through an examination of those behaviors.

Methods

Study objective
The purpose of this phenomenological study was to describe the lived experiences of non-English and limited English proficient Hispanic patients who have had a hospitalization in an acute care setting in the U.S. Data obtained from this study could be used to inform the body of knowledge regarding provider and patient perspectives of the hospitalized encounter as experienced by the Hispanic non-English speaking and limited English speaking patient.

Personnel
The study was conducted by the principle investigator. Additional members of the project included two bilingual bicultural research assistants who were certified interpreters, who assisted in the recruitment of participants, provided interpretation and transcription. Landmark Associates, a transcription company was utilized as the second transcriptionist. The Spanish language interpreters were trained by the researcher to recruit participants. In cross-cultural research efforts should be made to include an interpreter who is bicultural or has an understanding of that particular cultural group (Liamputtong, 2008). This provided the researcher with accurate interpretation and the cultural context that surrounded the interpretation; doing so added richness to the data (Adamson & Donovan, 2002; Temple,
Also, employing certified Spanish language interpreters can avoid some of the challenges to the research process that occur with cross-language qualitative research (Squires, 2009; Wallin & Ahstrom, 2006). Underestimating the role of the interpreter as an active research participant and not utilizing certified interpreters may alter the interpretation and description of data (Adamson & Donovan, 2002; Esposito, 2001; Kapborg & Bertero, 2001; Liamputtong, 2008; Squires, 2009; Temple, 2002; Thomas & Pollio, 2002; Wallin & Ahstrom, 2006). To that end, both bilingual research assistants were also Hispanic and familiar with the cultural context and nuances of the participant population.

**Tools**

The following documents were written in English and then translated into Spanish and then back translated by two different translators: 1) Informed consent – Appendices IA and IB; 2) Study information flyer placed at recruitment locations – Appendices IIA and IIB; 3) Telephone Script Appendices IIIA and IIIB; and 4) Demographic sheet – Appendices IVA and IVB.

**Sample**

All participants were recruited through purposive sampling methods. Purposive sampling allows the researcher to intentionally select participants who have experienced the phenomenon under study (Munhall, 2007; Thomas & Pollio, 2002). In the hermeneutic research tradition, the participants’ experiences, during a specific time and setting are under study and do not require a randomized sample that is representative of the general population (Morse & Field, 1995; Speziale & Carpenter, 2007; Steeves, 2000).

The desired sample size for hermeneutic phenomenology ranges from six to twelve and is adequate to obtain a rich description (Sandelowski, 1995; Thomas & Pollio 2002).
Lived Experience NEP LEP Hospitalized Patient

Additional participants may be necessary to facilitate data saturation or efforts to recruit have been exhausted (Morse & Field, 1995). Data saturation was met with eleven participants, at which point, no new themes emerged.

Setting

Ten of the eleven participants were recruited from one area community center that has a significant Hispanic population in the Washington, DC and Maryland area. The interviews were conducted face to face at a mutually agreed upon location and time. Ten of the participant interviews were conducted on-site in a room with a closed door provided by a clinic affiliated with the community center. Attempts were made to minimize disruptions, but on occasion the interviews were interrupted by clinic staff or the participant’s cell phone or infant. The other interview was conducted in the participant’s home, which was brightly lit and comfortable. The participant’s spouse was present for part of the interview.

Inclusion and Exclusion Criteria

Individuals were considered for inclusion if they were non-English speaking or limited English speaking and of Hispanic ancestry, male or female, 21 years of age or older, and had experienced hospitalization in the U.S. for at least 24 consecutive hours within six months prior to recruitment in the study. Exclusion criteria included individuals with a past or present history of mental illness, substance abuse or under medical care for an acute illness, younger than 21 years of age. Individuals were also excluded if they had been hospitalized longer than six months prior to participating in the study, or for less than 24 consecutive hours within the six months prior to recruitment.

Recruitment
The researcher disseminated 200 recruitment flyers at an annual Hispanic health fair, which yielded no potential participants. Potential participants were later identified through three primary sources: a) community centers utilized by a significant Hispanic population, b) interested persons who contacted the research assistant directly, and c) referral by the clinic healthcare provider affiliated with the community center. Potential participants were contacted by the bilingual research assistants in person and by telephone. The researcher and research assistants recruited on site during the period of October 2013 through April 2014. The research assistant was provided with a password protected cell phone by the researcher for this purpose exclusively. A total of 94 individuals were contacted; 59 of them did not meet the inclusion criteria. Of the 35 individuals who met the inclusion criteria, 11 agreed to participate in the study. The research assistant reviewed the purpose of the study with potential participants along with expectations using the previously prepared and translated script. A script describing the study and expectations of participants was prepared and translated into Spanish by the researcher and professional translators prior to the study. The researcher was responsible for obtaining informed consent from the participants through the bilingual research assistants (Appendices IV and V) prior to the start of the interviews. All participants asked to have the consent read to them regardless of their ability to read or write. Three of the participants reported inability to read and write, but were able to consent with their signatures. The consents were witnessed by either the researcher or one of the research assistants.

**Data Collection**

**Interview Process**

In hermeneutic phenomenology the researcher serves as a guide. This facilitates the participant in telling his or her story with minimum interference or bias of the researcher.
Unstructured interviews allow the researcher and participant to engage in a rich discussion in which the essence can emerge (Morse & Field, 1995; Thomas & Pollio, 2002). To aid in the process of telling the story, non-English speaking and limited English speaking Hispanic participants told their narrative in Spanish. All communication was conducted through the bilingual research assistant. To minimize errors in communication, the researcher and the bilingual research assistants conducted practice interviews with one another, prior to interviewing participants for the study. This assisted the researcher and Spanish speaking research assistant to develop an ease in the triangular conversation.

Each interview began with introductions of the researcher, research assistant and participant. After obtaining informed consent (Appendices IV and V) and socioeconomic demographics (Appendices II and III), the researcher asked an initial broad open-ended question to expand on the participant’s understanding of the interview. This was followed by the question “Tell me about an experience during your hospitalization that stands out to you”. Kahn (2000) recommended that novice researchers formulate a list of probing questions as a reference guide (Table 1), but that the questions be asked in a manner that allows the interview to flow like a conversation.
These probing questions proved to be important in eliciting the voice of the participant, particularly those who seemed initially hesitant or reticent. The bilingual research assistant provided interpretation to the researcher and followed up with any cultural context of that interpretation. This would allow the interpreter to state exactly what the participant said without changing the meaning of the statement. The advantage of this method is that the researcher remained in the research process and it ensured that the statement was that of the participant and not the interviewer. One of the disadvantages of this method was that the flow of the interview process could be disrupted, which was the case in several of the interviews in this study. Several of the participants were very animated about their

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**Guiding Interview Questions**

1. Tell me about your understanding of why we are meeting today.
2. Tell me about an experience during your hospitalization that stands out to you.
3. How many days were you in the hospital?
4. Describe your experience in the hospital.
5. When you think about when you were in the hospital, describe a good experience?
6. What do you think made it a good experience?
7. When you think about when you were in the hospital, describe a bad experience?
8. What do you think made it a bad experience?
9. What did you think about your overall experience in the hospital?
10. What did you think about health care in the U.S.?
11. Is there anything you would like to add?
experiences and would speak without pause, which made it difficult for the research assistant to interject for interpretation. Participant responses that required clarification or further probing were asked in a non-leading fashion to avoid bias (Speziale & Carpenter, 2007). Although, the time frame was anticipated to be extended due to the primary language, communication characteristics and patterns of the study participants (Thomas & Pollio, 2002), this did not occur. A communication pattern among Hispanic populations is to engage in small talk with others as a way to build rapport (Dayer-Berson, 2014). The interview time ranged from 20 minutes to 60 minutes. Nine of the interviews were digitally recorded. Two participants did not agree to being digitally recorded, but allowed the researcher and research assistant to record their responses in writing. All interviews were conducted at a mutually agreed upon private location. At the end of the interview, participants received a small remuneration of a $20 gift as a consideration for travel costs and inconvenience.

Lastly, the interview concluded with the researcher asking the participant to contribute or add any final comments. At the end of each interview, participants were asked if they would be willing to be contacted after when the interviews were completed to review the results with the researcher. Three of the participants agreed to be contacted.

**Audit Trail**

The researcher and research assistant maintained self-reflective journals. Journaling is another method of written reflection that lends credibility and adds rigor to the study (Kahn, 2000). The interviews and journals were kept as part of the audit trail. A detailed audit trail was kept and contained field notes on the observations noted during the interaction (Cohen, Kahn & Steeves, 2000; Thomas & Pollio, 2002). These field notes provided background, contextual data and participant observant information that enriched the interview data and aid in the interpretation and search for meanings (Merleau-Ponty, 1958/2004).
Data Analysis

The collected demographics data were analyzed using IBM SPSS statistical software to conduct univariate analyses to obtain descriptive statistics of the sample (Polit, & Beck, 2009). The data from the interviews were analyzed in the hermeneutic tradition which requires immersion in the data on several levels. In essence, interpretation was recursive in nature and the researcher sought meaning within each individual narrative and between the narratives, until no new meanings emerge (Cohen, Kahn & Steeves, 2000; Speziale & Carpenter, 2007). There was added complexity in this study as the narratives needed to be translated from Spanish to English. Because the use of a language interpreter may introduce a threat to the validity of the study, researchers suggest using a systematic and consistent approach to increase reliability (Kapborg & Bertero, 2001). To that end, a data analysis process developed specifically for cross-cultural qualitative research by Lopez, Figueroa, Connor and Maliski (2008) was utilized to translate the data from Spanish to English (Appendix VI). This process was adapted from Brislin’s 7-step translational model used in translating written texts (Lopez et al., 2008): 1) each digitally recorded interview was read in Spanish once by the translator to obtain a sense of the narrative, 2) each digitally recorded interview was transcribed in Spanish verbatim by the transcriptionist, 3) the translator checked the transcribed data for syntax errors, 4) problematic phrasing within the text was corroborated with a Spanish-speaking colleague and the recommended Real Academia Espanola dictionary, 5) a translation log was maintained of all unknown words and phrasing, 6) any needed revisions to the transcripts were made and documented, and 7) the completed translations were analyzed by the researcher. This adapted process was utilized by Landmark Associates, the researcher and research assistant to provide consistency throughout the transcription of all participant interviews.
The process of data analysis is circular and began as soon as possible following the translation. Immersion in the data began as soon as the first transcript was translated. For this study, there were three sets of transcripts: 1) the interviews transcribed verbatim in Spanish, 2) the interviews transcribed verbatim in English, and 3) the interviews translated from Spanish to English. The analysis of the data occurred in three phases (Morse & Field, 1995; Speziale & Carpenter, 2007; Thomas & Pollio, 2002) and the process was followed within and across each data set. Initially, each digital recording was listened to again and notes were taken. Then each transcript and its corresponding field notes were read several times in their entirety. The researcher spent a minimum of 2 hours with the initial reading of each transcript (Thomas & Pollio, 2002). As the transcripts were read and reread, any sentences that appeared revealing were highlighted. In the second phase, each transcript was read and reread line by line for similarities and differences in those highlighted areas between transcripts, looking for themes to emerge. According to Thomas and Pollio (2002), researchers must consider meaning in specific words and also within the context they were spoken by the participant and consideration must be given to the entire narrative. The initial process of searching for themes was done manually and then repeated in NVIVO, a qualitative research data management program. The individual texts were analyzed again across transcripts to check for supportive data to support the themes. It is important that the overarching themes that are developed are captured in the individual words of the participants (Saldaña, 2009). Thomas and Pollio (2002) coined the phrases, global themes to describe the overarching themes and ‘thematic structure’ to describe the collection of findings.

Data analysis is not complete until data saturation is verified, that is, when data are redundant after several participant interviews (Fryer, Mackintosh, Stanley & Crichton, 2012; Speziale & Carpenter, 2007). As recommended by Thomas and Pollio (2002) as patterns and themes clearly emerge, 2 more participants should be interviewed to confirm no emergence
of new themes. At this point, the phenomenon is considered to be “well-described”. The researcher and the research assistants began to see consistent themes after eight interviews without the emergence of new themes. To discern if the homogeneity of the sample, with more women than men and reason for hospitalization, was a factor in preventing further emergence of themes, the researcher sought to recruit and interview male participants or participants with varied reasons for hospitalization. Two of three additional participants met the criteria and no new themes emerged. After the analysis was completed, the researcher presented the findings to those participants who agreed to be contacted.

**Trustworthiness**

The responsibility of the researcher is to conduct a methodologically sound and ethical study. In qualitative research, trustworthiness refers to the rigor of the study (Lincoln & Guba, 1985). However, for a number of reasons, there is much discussion in the literature about how to establish or evaluate trustworthiness and rigor (Davies & Dodd, 2002; de Witt & Ploeg, 2006; Graneheim & Lundman, 2004; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Munhall, 2012; Pereira, 2012; Porter, 2007; Pyett, 2003; Rolfe, 2006; Ryan-Nicholls & Will, 2009; Torrance, 2010; Tracy 2010).

Several divergent discussions are present in the literature regarding trustworthiness and evaluative criteria. Some of the discussion revolves around the development of different terminologies or different evaluative criteria to either separate from quantitative research or define qualitative research (Ryan-Nicholls & Will, 2009; Sandelowski, 2000; Sandelowski, 2006), or the development of evaluative criteria with concepts that are more fitting for the research paradigm and methodology (Davies & Dodd, 2002; de Witt & Ploeg, 2006; Rolfe, 2006; Welford, Munford, & Casey, 2012). Conversely, researchers offer criteria that are overarching concepts that contain unifying terminology that can be applied across qualitative
paradigms or both qualitative and quantitative paradigms (Morse, Barrett, Mayan, Olson & Spiers, 2002; Tracy, 2010).

Finally, the controversy of following a set of guidelines to conduct phenomenological research is discussed in the literature. Some argue that utilizing a particular method as if following a recipe is in conflict with the tenets of phenomenology. But, offering a much more pragmatic view, Munhall (2012), Pereira (2012) and Welford, Mumford and Casey (2012) suggested that while following guidelines is formulaic, it is a necessary and essential component for learning, understanding and implementing the research process for novice researchers. With that in mind, the criteria for trustworthiness that were utilized for this study are credibility, transferability, dependability and confirmability, which were established by Lincoln and Guba (1985). The author chose these criteria as they are considered to be the essential components for evaluating the rigor of a qualitative study.

**Credibility.** Credibility is a criterion that establishes the validity of the findings. Any flaws in the recruitment of participants, insufficient sample size (Sandelowski, 1995), data collection and data analysis can threaten credibility (Lincoln & Guba, 1985; Wimpenny & Gass, 2000). The use of an interpreter for the interviews (Esposito, 2001; Kapborg & Bertero, 2001; Liamputtong, 2008; Temple, 2002) and translated texts (Chen & Boore, 2009; Lopez et al, 2008) are potential threats to the credibility of the study.

To reduce the threats to credibility, the following strategies were implemented: 1) the study employed two bilingual bicultural research assistants who also served as the interpreters. Both were bicultural and had an understanding of the overarching cultural themes of the cultural group (Liamputtong, 2008), 2) the interpreters and researcher conducted mock interviews prior to the start of the study to develop a rapport and understanding to minimize communication errors and ensure that the interviewing style was consistent with the hermeneutic tradition, 3) during the interviews, the interpreter was an
active participant in the research process (Esposito, 2001; Kapborg & Bertero, 2001), 4) verbatim transcription of interviews into Spanish was used; all translated text followed a standardized process of translation by two different translators prior to interpretation (Lopez et al., 2008), 5) the researcher and interpreters bracketed throughout the study by maintaining journals and using the bracketing interviews and debriefing to reduce bias (Cohen, Kahn & Steeves, 2000; Gearing, 2004; Laverty, 2003; Speziale & Carpenter, 2007; Temple, 2002; Tufford & Newman, 2010), and 6) participants were invited to hear a presentation of study results by the researcher via an interpreter. The researcher utilized the dissertation committee, who has expertise in hermeneutic phenomenological research throughout the research process.

**Transferability.** Transferability is accomplished when the findings of the study can be applied to other groups (Lincoln & Guba, 1985). The term transferability has been interchanged with the term generalizability, a term used in quantitative research. Some qualitative scholars argue that the concept of transferability is counter to the philosophical principles of qualitative research in which the aim is to provide rich in-depth description of a specific phenomenon within a specific historical and cultural context of a particular individual (Munhall, 2011; Tracy, 2010). However, the more widely held perspective conceptualizes transferability or generalizability as a transfer of knowledge or resonance— a feeling of insight or connection with the reader (de Witt & Ploeg, 2004; George & Thomas, 2010; Graneheim & Lundman, 2003; Koch, 2006; Pyett, 2003; Ryan-Nicholls & Will, 2009; Thomas & Pollio, 2002; Tracy, 2010).

Transferability refers to the applicability of the findings to a particular context or situation of the reader (George & Thomas, 2010; Graneheim & Lundman, 2003; Koch, 2006; Pyett, 2003). Therefore, it is essential for the researcher to present the findings with transparency that will aid the reader in understanding how the researcher analyzed and
interpreted the data (Pereira, 2012; Roberts, Priest & Traynor, 2006). As Graneheim and Lundman noted, “There is no single correct meaning or universal application of research findings, but only the most probable meaning from a particular perspective”. (pg.110).

**Dependability.** Dependability pertains to how well the researcher establishes the credibility of findings and if the data could be replicated with the same subjects (Morse & Field, 1995). It is also a criterion of reliability (Lincoln & Guba, 1985). Speziale and Carpenter (2007) noted that credibility is needed for dependability. Demonstration of dependability was addressed by the detailed record of data and the data analysis; the maintenance of the audit trail that included journals and field notes and the bracketing interviews were included in the data analysis (Thomas & Pollio, 2002).

**Confirmability.** Confirmability pertains to the process of limiting bias in the study and the documentation (Lincoln & Guba, 1985). Demonstration of confirmability was addressed by the detailed record of the data and the data analyses; the maintenance of the audit trail that included journals, field notes and the bracketing interviews were included in the data analysis (Thomas & Pollio, 2002). This assisted in replicability and validity (Speziale & Carpenter, 1998).

**Limitations**

Several anticipated limitations were noted with this study. 1) The inability of the researcher to directly communicate with the participants in Spanish and the need to use an interpreter added another layer of interpretation and therefore could increase the risk of misinterpretation of the data; 2) The interview process was disrupted by the flow of the interpretation process and therefore may have interfered with the ability to obtain rich descriptions of the experience from the participant; 3) Sample size, recruiting the sample from a limited geographic area and lack of variety for reason of hospitalization may decrease
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transferability, and 4) Lastly, concerns about deportation may have prevented some individuals from agreeing to participate in the study or from providing honest responses during interviews.

**Ethical Considerations**

The study was submitted to the Institutional Review Board (IRB) at Villanova University for approval. Informed written consent was obtained from participants in Spanish (Appendix IA, IB). Those who were illiterate; the consent form was read to them; they signed the form which was witnessed. This form was written in English, translated into Spanish and translated back to English by two additional translators. Although researchers have found that participants have expressed a feeling of catharsis after participating in interviews (Morse & Field, 1995; Thomas & Pollio, 2002), there was a risk that some may experience distress when recalling a painful memory. Participants in need of immediate counseling services would have been referred to Montgomery County Crisis Center or to their usual source of care and the participants were informed that they would be held responsible for all fees in the event that they experienced distress that necessitated referral for counseling. The researcher would have stayed with participants until they were safe and connected to services.

Offering monetary incentives for participation in research studies is considered controversial, as the amount offered may create an undue influence and coercion for the individual to participate (Cohen, 2000; Grant & Sugarman, 2004; Steinke, 2004). However, monetary incentives have been noted to be a successful intervention for recruitment of minority participants (Ndumele, Ableman, Russell & Gurrola, 2011; Shedlin, Decena, Mangdu & Martinez, 2011; Yancey, Ortega, Kumanyika, 2006). Therefore, participants were provided with a small remuneration of a $20 gift card as a token of reciprocity for participating in the study. Participants were told that participation was completely voluntary,
they had the right to decline to participate in the study or to withdraw from the study at any point and that compensation was dependent upon completion of the study.

The signed consent forms were separated from the interviews and placed in a locked firebox. Participants were given pseudonyms to provide confidentiality and anonymity. Also, random numbers were assigned to code the raw data. The only identifiers on the transcript records are the assigned pseudonym. Only the researcher, translator, the dissertation committee and transcriptionists had access to the tapes and transcripts during the transcription phase. Only the researcher has access to the digital audio recordings and raw data after completion of the transcription and study. All digital recordings and raw data are stored on a portable hard drive that is password protected and is locked in a firebox following the completion of the research study for three years or as directed by the IRB and will only be accessed by the researcher. The tapes and raw data will be destroyed after that period.

**Summary**

Hispanic populations are some of the fastest growing culturally and socioeconomically diverse populations residing in the U.S. (United States Census Bureau [USCB], 2011). There is a dearth of literature related to the perceptions of health care related to a hospitalization experience and therefore this study adds to this body of knowledge by providing a rich understanding of how patients with language barriers experience inpatient hospitalization. Research to date has focused primarily on the experiences of healthcare professionals providing primary or emergent care related to patients with language barriers.

This qualitative study described the lived experiences of non-English and limited English speaking Hispanic individuals associated with a past hospitalization in the U.S. The hermeneutical approach, based in the tradition of Maurice Merleau-Ponty, facilitated the exploration of phenomena experienced by an at-risk and underserved population whose voice
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is limited in the health care system. Using purposive sampling, eleven participants were recruited from community centers within the Washington, DC, and Maryland area. Participant recruitment ended when emergence of new data ended and the phenomenon appeared well described resulting in rich description of the phenomenon. A research assistant reviewed the study purpose and expectations of participants with potential participants.

The chosen criteria for rigor in this study were established, maintained and evaluated throughout the study following the criteria of trustworthiness for credibility, transferability, dependability and confirmability established by Lincoln and Guba (1985). The researcher, participant and bilingual bicultural certified interpreters engaged in-depth unstructured interviews, which were transcribed. The transcripts were analyzed using hermeneutic phenomenology. To increase the validity of the research in cross-cultural research, interpreters were chosen who were knowledgeable about the cultural and communication nuances of a particular cultural group. One of the disadvantages of this method is that the flow of the interview process could be disrupted. To maintain a sense of openness to receiving new knowledge regarding the research process and phenomenon, the researcher research assistants participated in bracketing interviews and debriefings (Thomas & Pollio, 2002) and maintained journals.

The analysis of the data occurred in an iterative process of reading and rereading individual transcripts, highlighting revealing text. Highlighted text were searched for similarities and differences within and across transcripts, looking for themes to emerge (Morse & Field, 1995; Speziale & Carpenter, 2007; Thomas & Pollio, 2002). After the data were analyzed findings were presented to the participant who agreed to hear the results of the study and participate in a member check.

Conclusion
It was anticipated that this study would add rich data to the current body of nursing knowledge and would inform health care providers and policymakers about the impact of the perceptions on health outcomes experienced by the study population. Hermeneutic phenomenology was the appropriate method for this research study, which allowed the voiceless to be heard.
Chapter IV: Results

In this chapter, findings of this phenomenological study of the lived experiences of 11 non-English speaking or limited English speaking Hispanic participants who had been hospitalized are described. The following sections describe the data collection, the data analysis, description of the sample, the six themes and subsequent subthemes and an exhaustive description of the phenomenon.

Description of the Sample

The sample consisted of 11 non-English or limited English speaking individuals who had experienced a recent hospitalization (Table 1). Seven of the participants were identified through community centers they frequented. Three participants were identified by referral from the clinic healthcare provider affiliated with the community center. Lastly, one participant was identified by referral of the research assistant associated with this study.

Each participant completed a demographic form developed by the researcher, which had been written in English, translated into Spanish, and then translated back to English (Appendix I). The sample consisted of eight women and three men. The age of the participants ranged from 24-86 years, with a mean age of 43.7 years.

Ten of the participants reported being hospitalized once in the past six months and one reported being hospitalized three times in the last six months. The reason for hospitalizations ranged from childbirth to medical-surgical admissions and days spent in the hospital from 1.5 to 15. Five of the participants reported not speaking English at all (NEP), while six reported speaking English “not well” (LEP). One participant was from Puerto Rico (PR) and 10 participants emigrated from Central America; two from Honduras (Hon), two from Guatemala (Gua) and six were from El Salvador (El Sal). The years spent living in the U.S
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ranged from 2 to 24 years. One participant has lived in the U.S. for less than five years, five participants between 6 and 10 years, and five greater than 10 years.

The overwhelming majority of the participants had health insurance coverage. All but two of the eleven participants reported that they had health insurance coverage. Seven were covered by Medicaid, two by Medicare, and one was insured by a private insurance company.

Eight of the participants were unemployed, two reported full-time employment and one was retired. Six participants had a high school education (HS), two had less than a high school education (<HS) and three reported no formal education (N). Four participants were single (S), four were married (M), two were living with a partner (P) and one was divorced.

Table 1- Descriptive Data

<table>
<thead>
<tr>
<th>Age</th>
<th>Country</th>
<th>Edu</th>
<th>#Employment</th>
<th>Yrs. In US</th>
<th>Marital Status</th>
<th>NEP/LEP</th>
<th>Health Ins.</th>
<th>Diagnoses</th>
<th>LOS Hosp.</th>
<th># of Hosp in 6 months</th>
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<tr>
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<td>Hon</td>
<td>None</td>
<td>N</td>
<td>8</td>
<td>S</td>
<td>NEP</td>
<td>Medicaid</td>
<td>Childbirth</td>
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<tr>
<td>32</td>
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<td>HS</td>
<td>N</td>
<td>6</td>
<td>S</td>
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<td>Medicaid</td>
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<tr>
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<td>2</td>
<td>S</td>
<td>NEP</td>
<td>Medicaid</td>
<td>Childbirth</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>36</td>
<td>Guat</td>
<td>HS</td>
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<td>7</td>
<td>P</td>
<td>LEP</td>
<td>None</td>
<td>Childbirth</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>32</td>
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<td>11</td>
<td>D</td>
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<td>Ret</td>
<td>13</td>
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<td>Spinal disc surgery Syncope</td>
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</tr>
<tr>
<td>57</td>
<td>El Sal</td>
<td>HS</td>
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<td>24</td>
<td>M</td>
<td>NEP</td>
<td>Medicaid</td>
<td>Syncope 1.5</td>
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<td>1</td>
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<tr>
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<td>F/T</td>
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<td>P</td>
<td>LEP</td>
<td>None</td>
<td>Childbirth</td>
<td>2.5</td>
<td>1</td>
</tr>
<tr>
<td>28</td>
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<td>8</td>
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<td>1</td>
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<tr>
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<td>47</td>
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<td>LEP</td>
<td>Medicaid</td>
<td>Pneumonia 8</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>
Data Collection

Nine of the participant interviews were audio recorded and two were recorded in writing because the participants did not wish to be recorded. Field notes were taken by the researcher throughout the interview process. Reflection and journaling were conducted by both the researcher and interpreter after each interview. These reflections and field notes were read and included as part of the analysis process to further inform the study. In keeping with the recursive nature of the hermeneutic tradition, the researcher sought meaning within each individual narrative and between the narratives, until no new meanings emerged (Cohen, Kahn & Steeves, 2000; Speziale, Carpenter & Rinaldi, 2007).

After eight interviews, consistent themes emerged. To discern if the homogeneity of the sample, that is, women hospitalized for childbirth, was a factor in preventing further emergence of themes, the researcher recruited and interviewed three additional participants: two women, and one male and participants who were hospitalized for reasons other than childbirth.

Analysis of the Data

There was added complexity in this study as the narratives required translation from Spanish to English. The data analysis process developed specifically for cross-cultural qualitative research by Lopez, Figueroa, Connor and Maliski (2008) was utilized to translate the data from Spanish to English (See Figure 1). This process was adapted from Brislin’s 7-step translational model used in translating written texts (Lopez et al., 2008): 1) each digitally recorded interview was read in Spanish once by the translator to obtain a sense of the narrative, 2) each digitally recorded interview was transcribed in Spanish verbatim by the
transcriptionist, 3) the translator checked the transcribed data for syntax errors, 4) problematic phrasing within the text was corroborated with a Spanish-speaking colleague and the recommended Real Academia Espanola dictionary, 5) a translation log was maintained of all unknown words and phrasing, 6) any needed revisions to the transcripts were made and documented, and 7) the completed translations were analyzed by the researcher. This adapted process was utilized by Landmark Associates, a transcriptionist company, the researcher and research assistant to provide consistency throughout the transcription of all participant interviews.
For this study, there were three sets of transcripts: 1) The section of the interviews that were spoken in Spanish were transcribed verbatim in Spanish, 2) The section of the interviews that were spoken in English were transcribed verbatim in English, and 3) The Spanish transcripts were translated from Spanish to English. The analysis of the data occurred in three phases (Morse & Field, 1995; Speziale & Carpenter, 2007; Thomas & Pollio, 2002) and the process was followed.
within and across each data set. Initially, each digital recording was listened to again and notes were taken. Then each transcript and its corresponding field notes were read several times in their entirety. The researcher spent a minimum of 2 hours with the initial reading of each transcript (Thomas & Pollio, 2002). As the transcripts were read and reread, any sentences that appeared revealing were highlighted. In the second phase, each transcript was read and reread line by line for similarities and differences in those highlighted areas between transcripts, until themes emerged. As part of the interpretive tradition, consideration was given to finding meaning in specific words as well as the context in which they were spoken by the participant and within the entire narrative (Thomas & Pollio, 2002). The initial process of searching for themes in each of the transcripts was completed manually. The individual texts were analyzed again across transcripts to check for supportive data to support the themes. The overarching themes were developed and captured from the individual words of the participants (Saldaña, 2009). The transcripts were then uploaded into NVIVO, a qualitative data management software program, to manage the data for further analysis. Using both of these approaches, the same themes emerged.

**Findings**

The 30 themes developed using the manual data analysis procedure and the management software were further refined to six themes, each with subthemes: 1) Communication: 1a) health literacy, 1b) Illness and advocacy, 1c) providing empathy; 2) Concerns about safety; 3) Positive experiences: 3a) Anticipating needs, 3b) Attention, 3c) Family support, 3d) Organizational support; 4) Negative Experience: 4a) Delays in treatment, 4b) Maltreatment, 4c) Lack of respect, 4d) Losses 4e) Personnel issues, 4f) Family support, 4g) Lack of organizational support; 5) Responses to negative experiences: 5a) Anger, 5b) Discomfort, 5c) Fear and Apprehension, 5d) Powerlessness, 5e) Stress; 6) Healthcare system and fairness, equality and just care. (See Table 2)


<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Health Literacy</td>
</tr>
<tr>
<td></td>
<td>Illness and Advocacy</td>
</tr>
<tr>
<td></td>
<td>Providing Empathy</td>
</tr>
<tr>
<td>Concerns about Safety</td>
<td></td>
</tr>
<tr>
<td>Positive Experiences</td>
<td>Anticipating Needs</td>
</tr>
<tr>
<td></td>
<td>Attention</td>
</tr>
<tr>
<td></td>
<td>Family Support</td>
</tr>
<tr>
<td></td>
<td>Organizational Support</td>
</tr>
<tr>
<td>Negative Experiences</td>
<td>Delays in Treatment</td>
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<td>Maltreatment</td>
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<tr>
<td></td>
<td>Lack of Respect</td>
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<td>Losses</td>
</tr>
<tr>
<td></td>
<td>Personnel Issues</td>
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<td></td>
<td>Family Support</td>
</tr>
<tr>
<td></td>
<td>Lack of Organizational Support</td>
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<tr>
<td>Responses to Negative Experiences</td>
<td>Anger</td>
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<tr>
<td></td>
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<tr>
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<td>Powerlessness</td>
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<td></td>
<td>Stress</td>
</tr>
<tr>
<td>Healthcare System Fairness, Just and Equality</td>
<td>Fairness, Just and Equality</td>
</tr>
</tbody>
</table>

Table 2. Themes and Subthemes

Theme 1 – Communication

Communication is defined as the process of exchanging thoughts, feelings or information in a written, verbal or behavioral manner (Soukhanov, 1992). For the participants, communication was an integral part of their hospital experience. In this study, participants described their encounters with healthcare providers (nurses and physicians), and hospital staff (lactation consultants and ancillary support). Within the theme of communication, three subthemes emerged: illness and self-advocacy, health literacy and empathy.

During the encounters between participants and nurses, the majority of the communication focused on assessment of and meeting the participants’ physical health needs with some focus on patient education. In contrast, the communication encounters between participants and physicians centered on providing and receiving information related to their diagnoses and treatment plan.
Participants and healthcare providers or hospital staff attempted to communicate with each other using various methods such as hospital-provided interpreters, family members serving as interpreters, bilingual providers, fragmented English and Spanish and body language. There were differences in utilization of hospital-provided interpreters between those who were limited English speaking and non-English speaking. Nine of the 11 participants reported utilization of interpreters at some point during their hospitalization. However, participants reported that interpreters were not consistently utilized in all encounters with healthcare providers. Interpreters were used more often during encounters between participants and physicians than during encounters between participants and nurses regardless of the participants’ English speaking ability.

Only three of the participants reported staying on units with bilingual nursing staff or utilizing interpreters throughout their hospital stay. Others reported having access to bilingual nursing staff or utilizing interpreters infrequently; during labor and delivery, at the point of admission or discharge, during patient education or when nurses were completing documentation or paperwork. Seven of the participants reported utilizing face-to-face interpreters only; only three reported utilizing face-to-face and phone interpreters. Of particular note, of the five participants who utilized interpreters at the beginning of their hospital stay, three had to initiate the request for interpreters in later conversations. The other two participants relied on limited English speaking skills or family and friends throughout their stay.

For five of the six limited English speaking participants, fragmented sentence phrasing was utilized most often with the participant speaking “a little English” or the healthcare provider, mainly nurses, speaking “un poquito Espanol” (“a little Spanish”), communicating with bilingual nurses, and lastly through interpreters. Non-English speaking participants reported that they most often communicated through Spanish speaking interpreters who were
not professionally trained as interpreters and less often with professionally trained interpreters and bilingual healthcare providers. Additionally, participants reported reliance on family members, friends or neighbors to help with interpretation. Of those few bilingual healthcare providers, the majority were reported to be nurses, with only two participants reporting that they communicated with a bilingual physician.

While several of the participants spoke of interpreters and their importance, only three of the participants mentioned interpreters without prompt and discussed how their utilization was an integral part of their care. One participant described her communication with the healthcare providers as “bien”: “The doctors and nurses didn’t speak Spanish, always had a translator. Mr. or Mrs. Translating…Volunteers.” Another participant noted, “I cannot speak any English, but they have the team of interpreters by phone or staff who help there…first of all the attention of nurses and doctors. The care was excellent.”

In addition to assisting the participant with communication, the interpreter was instrumental in the participant’s ability to understand treatment, which is highlighted in this narrative: “She was an interpreter. She didn’t leave me alone at any moment. She followed my case…. She explained everything to me…I received a very good service.”

Participants also noted the tone and nonverbal behaviors, facial expressions and body language of the nurses as a reflection of the care they were providing:

When I finally saw her attitude, the expression on her face, and her unwillingness to do stuff, I asked her if she had a problem. She told me they were short on staff and that all women had decided to deliver their babies at the same time.

The same participant went on to say:

Yes, a nurse. My husband didn’t like that because the way she was treating me was…I don’t know. Her manners when talking to me…if she says to me: try this or position yourself like that…but no. She said: “let me see” and …she was very rough.

As the participant continued, she described an encounter with the housekeeping staff and contrasted this encounter with the encounter she experienced with the nurses.
Because they treat you well, with more love. They would ask: “How does the new mommy feel?” So, they showed me more love. I felt good. Someone was concerned. Instead the other ones would come in and they would tell me: “Did you call?” They wouldn’t say anything else and you feel things changing, you feel the difference. So, they [cleaning ladies] are nicer.

Similarly, another participant described and compared the care received from different nurses. In this instance the non-verbal behaviors, specifically the nursing skills, were compared. “Everything…even when she gave me insulin she was gentle, instead downstairs… I’m not sure if it was a new nurse, but she had a heavy hand. Yeah, when they gave me insulin they pinched me really hard.”

Another participant communicated what was inferred by other participants: while language concordance between patients and healthcare providers is important, it is one component of providing care. When describing why he felt that nurses who “speak Spanish are the best” the participant clarified that it was not the nurses’ ability to speak Spanish that he perceived to be excellent, but rather, the way or manner in which the nurses performed their job or treated him. The nurses’ ability to speak Spanish was an indication that they cared enough to know Spanish and be able to speak to him:

No, there’s no difference. What pleases me is that they speak to me well and do the job they’re supposed to do. That’s what pleases me. There’s not a difference between Hispanics and the nurses who speak English. I understand some English, a little bit not everything, but I understand.

Communication was the foundation of the patient experience. Participants noted the tone and nonverbal behaviors, facial expressions and body language of the nurses as a reflection of the care they provided. Interpreters were instrumental in the participants’ ability to understand treatment. Within the theme of communication, three subthemes emerged: health literacy, illness and self-advocacy, and empathy and are discussed below.
**Subtheme 1 - Health Literacy.** As participants spoke of their communication encounters, health literacy emerged as a subtheme. Title V of the Patient Protection and Affordable Care Act (2010), also known as the Affordable Care Act (ACA), has defined health literacy as “the degree to which individuals have the capacity to obtain, communicate, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness.” (p. 1252). Three participants spoke of access to care issues, difficulties in understanding treatment, challenges with the completion of paperwork and navigating the healthcare system. Many of these challenges were further exacerbated by the participants’ inability to understand written or verbal communication due to language discordance, that is, the participants and healthcare providers not speaking the same language.

Participants who were limited English speaking, reported varying levels of English fluency and literacy. Some participants stated that they could converse in English, but could not read or had limited understanding of written communication in English. Others reported that they could understand spoken English, but were unable to converse fluently. Non-English speaking participants also reported varying levels of literacy. Two of the participants reported the inability to read or write in Spanish, but could understand verbal instructions regarding their healthcare. Regardless of English speaking or reading ability, all participants preferred Spanish for communication and health education. Participants described their experiences as they sought to understand their health and to navigate the healthcare system.

This participant spoke with frustration regarding her experience:

> When they gave me the paperwork for the Social Security and the birth certificate for my daughter, no one helped me. No one offered to help me. You know that I don’t read or write in English or Spanish. So I didn’t know how to fill out the forms. It wasn’t until I was going to go home that the nurses asked for the forms and when they saw I didn’t have them. Then the nurses called someone to help me translate and fill out the forms.

Language discordance and poor health literacy affected another participant’s ability to
maintain his health insurance:

Oh yes! Sometimes I get instructions in Spanish, but not in the hospital. Sometimes the insurance company sends me letters (in English), but I have called them and requested the letters in Spanish. I don’t understand what they send to me in English. Sometimes I haven’t filled out forms because I don’t understand…For example, I requested Medicaid assistance …(unintelligible) and they helped me pay Medicaid expenses, which was about $419 every three months. They sent me a letter saying I had to renew the application, but I didn’t understand because I can’t read in English…

A different participant described relying on family to gain understanding of his health and course of hospitalization:

Everything they [doctors] told me I didn’t understand. When my son went to visit me, I would take advantage to communicate with the doctor. The doctor went to see me upon arrival, later another visit…. Three visits.

The same participant continued as he described how he sought to understand his medical conditions and medications after he received discharge instructions in English and he realized that he did not receive adequate information regarding a diagnosis of syncope from the nurse:

No, they didn’t explain anything, but I looked it up in the dictionary. It said it was the loss of consciousness, fainting. ….That’s what I do when I go to the pharmacy and they give me a new medicine. Before I take it I read about it and if there are words I don’t understand, I look them up in the dictionary… nausea, dizziness, and things like that. I have to take precautions before I take them.

These descriptions illuminated how language discordance and poor health literacy contributed to the difficulties experienced by participants as they sought to navigate the system.
Subtheme 2 - Illness and self-advocacy. This subtheme refers to the participants’ ability to communicate their needs or wants during a period of illness. Self-advocacy is defined as the ability to act or speak for one’s own needs (Brashers, Haas, & Neidig, 2009). Two participants found it physically and mentally challenging to speak in English to express their feelings or communicate their needs during their hospital stay. A limited English speaking participant with a chronic illness talked about his recent hospitalization:

…but when I’m bedridden and I can’t speak a lot; I swallow my words and let them do whatever they want to do. But when I can talk and I’m feeling a little better I ask them if it’s okay for them to be bitter and why are they employed in the hospital if they don’t do what they’re supposed to?

Another participant described the effort in trying to communicate when ill.

Well, I tried to talk, but I didn’t feel well because sometimes you want to say something but you can’t complete a sentence. Sometimes one is in pain and one can’t explain where in the body the pain is. That’s hard when you try to communicate and one doesn’t feel good about it.

These rich descriptions illuminated the communication challenges experienced during a hospitalization. Feeling ill diminished the participants’ ability to communicate and express their needs.
Subtheme 3 - Providing Empathy. Empathy is defined as “understanding others by entering their world”, (Zhu, 2011, pg. 116). The ability to understand participants’ inability to speak English is discussed in this subtheme. The participants’ perception of language concordance, that is, the ability for two people to speak the same language, was complex. Several of the participants acknowledged that the ability to communicate in English was important and yet, they stated that healthcare providers should be empathetic and understanding of their inability to speak English and make attempts to communicate in Spanish or provide language support. One of the three participants suggested that healthcare providers need to have greater empathy for non-English speakers, “We know that the English language is paramount in this country…. But by coincidence that we have many who do not speak English, like me. Then we need the help...” Another participant pointed to a need for greater understanding of language needs and language concordance, “…if they [healthcare providers] don’t speak Spanish well, at least they could try to understand… one doesn’t speak English…they can try to understand us.” Lastly, a third participant echoed a similar sentiment as the other two participants, asking healthcare providers for demonstration of empathy toward non-English speakers and to have a greater awareness of language needs so that patients can communicate their needs stating, “For those of us who don’t speak English, it’d be good if hospitals were more aware of the need of an interpreter. That way one can say everything about how we are feeling. But if one goes to the hospital and there’s not an interpreter, how do you explain everything one is feeling?”

Finally, this participant suggested treating patients with respect, by providing the standard of care and anticipating needs, “Well, one always likes to feel we are in good hands, to feel you are treated well, in a good manner...For example, to be on time with the medicine we are taking, checking on us [me and the baby]. I want to trust I can tell the nurse I need something...or that she is going to ask if everything is ok.”
Summary of Theme 1 - Communication and Subthemes

In theme one, participants described their communication experiences during a hospitalization. From their descriptions, three subthemes emerged; health literacy, illness and self-advocacy and providing empathy. Their descriptions illustrated challenges facing non-English and limited English speaking patients. These participants described a variety of methods utilized by them and healthcare providers to communicate during their hospital stay. While interpreters were utilized for the majority of the participants, their use was inconsistent. Participants perceived the manner in which they were touched, verbal tone and use of words by the nurses and physicians to convey caring or lack thereof. Further, participants’ ability to understand their health condition and treatments and to communicate their needs was impeded by language discordance with the healthcare provider and by illness. Written materials were not consistently provided in Spanish. Participants, regardless of English speaking ability, when given the choice, preferred to speak Spanish. Lastly, participants acknowledged the importance of speaking English; however, when they are seeking healthcare, they indicated that they should be able to receive care in a safe and effective manner and this is the responsibility of the healthcare provider as well as the participant.

Theme 2 - Concerns about Safety

Safety is defined as, ‘The condition of being safe; freedom from danger, risk or injury (Soukhanov, 1992, pg. 1586). The World Health Organization (WHO) defines patient safety as, “prevention of errors and adverse effects to patients associated with health care” (“Patient Safety”, para. 1, 2015). Concerns about safety were expressed by two of the limited English speaking participants who provided rich descriptions of the importance of understanding their treatment to avoid errors and mistakes. During the interviews, both participants spoke in a
serious tone as they discussed how important it was for them to have an understanding of their care. For them, the inability to understand could have negative impacts on their health. Below this participant noted:

Because of my condition if I don’t understand a word or if I have a question I ask: what does it mean or how to do it? I have to make sure I understand well because I can’t be guessing what they said. Because of my illness I need to know exactly about the process.

Further, the importance of having an interpreter to ensure safety by preventing mistakes was emphasized by another participant:

I request an interpreter each time. Even when I go to [doctor’s] appointments I request an interpreter. Even though I understand English well, I can make mistakes. The law states it: “If you need an interpreter, request one.” So I don’t regret it later. I always go ahead and request one: I’d like an interpreter to understand perfectly what they are doing to me, what I have? Where I’m going…?

This limited English speaking participant after receiving the wrong baby from the nursery suggested better monitoring and matching the mothers with their infants, “Maybe (you) can be more careful and more vigilant when dealing with baby names….double-check the baby name and if they are taking the baby to the right room…”

These accounts demonstrated that participants were keenly aware and concerned about the potential errors and mistakes that could have occurred due to language discordance.

**Theme 3 - Positive Experiences**

Experience as defined by Merriam-Webster is “something personally encountered, undergone, or lived through the act or process of directly perceiving events or reality” (“Experience” 2015, para. 2). Positive experiences for this study are defined as those events that occurred during the hospitalization that participants perceived to be good or beneficial to them. “Bien” (good), “bonita” (beautiful) were words used frequently to describe their positive experiences. Eight of the participants had mixed experiences, while three described their experience as completely positive from admission to discharge. The following
subthemes emerged from the participants’ descriptions: anticipating needs, meeting needs, attention, family and organizational support.

**Subtheme 1 - Anticipating needs.** Anticipation is defined as, “To act in advance to prevent or forestall or to foresee and fulfill in advance” (Soukhanov, 1992, pg. 79). For this study, anticipating needs is defined as the behaviors demonstrated by healthcare providers who attempted to address participant needs or concerns, provided care or assistance prior to participants requesting help. Three participants specifically spoke about the anticipation of needs as a factor that contributed to positive perceptions of care. One participant who had experienced many hospitalizations described the behaviors of the nurses whom he considered were providing quality care: “They (nice nurses) ask if I need water or if I use the call button when I need something urgent they come in. They tell me ‘I’m going to bring you pills or I’m going to give you an injection to help you with the pain.’ They are special to me.”

The notion of being present with the patient through tone and touch are represented in this participant’s narrative as she discussed the care she received during her hospitalization:

> The way she treated me was very kind, attentive to my needs… And after the baby was born, the night shift nurse, kindly talked to [woke me up] me early in the morning to give me the medicine, she would give me food when I had to take medicine…their treatment more than anything.

Being present for the participant and providing food with her medicine in the early morning hours was perceived as kindness. For another participant, anticipation of physical needs and recognition as an individual were appreciated and seen as ways used by the nurse-to build rapport:

> They called me by my name, they gave me their name and said: “anything you need you call me,” which nobody did in the ER. They also left water on my table, the urine container nearby, and I didn’t have to get out of bed even though there was a bathroom and a shower there.

Overall, it is illustrated through these rich descriptions that participants valued nurses who were more proactive in providing care and not responding to care needs only when
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requested. Participants appreciated knowing what to expect from the nurse, “just press the call button if I needed the nurse.” This guidance provided a level of comfort for the participants. Further, the attempt of the nurses to anticipate needs was seen by the participants as a display of caring and a way to build rapport.

Subtheme 2 – Attention. Through the narratives of four participants, the subtheme of attention emerged and, similar to anticipating needs, providing attention to the participants was associated with positive perceptions of care. Attention as defined by Merriam-Webster is, “the act or power of carefully thinking about, listening to, or watching someone or something; notice, interest, or awareness special care or treatment.” (Attention, 2015, para. 2). Participants used words “tended” or “checking” to describe this subtheme. This participant described the care she received following a complicated pregnancy that resulted in the premature birth of her child: “First of all the attention of nurses and doctors… The care was excellent, I’m not complaining. I repeat, I’ve been to other hospitals and it has left me very badly. And with my health problem, they were very outstanding, they were monitoring my baby to see if her [heart] was beating and then for me that has been very good experience.”

Three of the four participants described attention as monitoring the participant frequently, anticipating care, “they asked if I needed anything,” and responding to needs in what was perceived to be a timely manner. As one participant described; “They tended to me. They saw me immediately. The nurses were constantly checking on me, asking me if I was in pain. The nurses were nice.” A different participant described her care and experience in this manner:

[I] felt good, at peace. I felt good because they treated me well… they came to check on me constantly…They took good care of me because they kept checking on me and making sure everything was well…. Checking on the baby….

Further, two of the four participants’ narratives noted the attempt of the nurses to meet
language needs as a form of attention. Both of the participants smiled as they reflected on the nurses. One participant further described the communication with the “attentive nurses”. “They made an effort to speak Spanish”. Another participant elaborated on what is meant by “effort”: “The nurses made an effort to talk to me in Spanish. They spoke a little [Spanish]. They would ask me… and I know more or less a little [English]. They would ask me: ‘How are you?’ or ‘How are you feeling?’ I understood.” The use of the word “effort” in both of these narratives underscores the appreciation felt by the participants toward the nurses’ attempts to speak their language.

Lastly, according to another participant, when discussing the care received from the physicians and nurses, attention was described as addressing physical needs and listening to concerns:

Oh, the treatment was number one. Everybody, all the doctors were very attentive when I complained, whatever I could explain, and in the two occasions, I could see they were in and out and always checking on me. The nurses [were] very attentive with my medicines… I mean number one.

For these participants, attention was defined as providing medications, frequent monitoring, listening and addressing concerns. These actions were perceived by the participants as demonstrating caring and kindness.

**Subtheme 3 - Family Support.** Participants described family members and neighbors as being a source of support during positive and negative experiences of their hospitalization. Support is defined by Merriam-Webster, as providing assistance or help (“Support”, para.1, 2015). During positive experiences, the family members, and in one case, a friend, provided emotional support and language interpretation.

A participant described her experience when she received previous breastfeeding education with the nurse speaking “a little Spanish” and the patient speaking “a little
English”. She described how her neighbor served as an interpreter and reinforced the importance of breastfeeding during a teaching session conducted in English:

> A nurse who took care of me on Sunday afternoon spoke English, but when...there was a lady with me, someone from where I live...Yes, She understood everything. She told me about the importance of breastfeeding... that my milk is better.

Four participants spoke about reliance on family members to serve as language interpreters. Family members provided interpretation during various phases of the hospitalization. A participant described utilizing his son and daughter-in-law to interpret throughout his 36-hour hospitalization: “Everything they [doctors] told me I didn’t understand. When my son went to visit me, I would take advantage to communicate with the doctor. The doctor went to see me upon arrival, later another visit.... Three visits.”

Non-English speaking and limited English participants utilized and relied on family and friends with different levels of fluency to help them understand and communicate. When asked if there was someone to help him understand what was told to him at discharge, he responded; “Sometimes my wife or my daughter... My daughters can more or less understand English because they went to school for two years.” Participants deemed family members qualified to interpret because they understood more than the participant. This is noted as the participant described having the father of her baby provide interpretation during the delivery of their child:

> [Smiling] The baby’s father was helping me, because she (doctor) tried to speak a little....He speaks a little more than me. He speaks and understands more.....as I said, the baby’s father was there and they would also speak a little [Spanish] and I could understand a little bit because they spoke slowly. I would understand fragments and the baby’s father would also translate for me.

Further, participants trusted the interpretation because there was a prior relationship in which a level of trust was established. This non-English speaking participant spoke with pride as she recounted how her adult children were there to interpret:
[Smiling] I felt good when my daughter explained everything the doctors said because I didn’t really understand the doctors. The doctors would speak to my son-in-law and my daughter.

It was further clarified that the participant was not only referring to the inability to speak English, but also the inability to fully understand the course of her treatment and hospitalization without the help of her family to explain. This participant viewed her daughter’s presence as a form of love and she was grateful that her daughter could be there for her.

Participants relied on family for emotional support. Again, this non-English speaking participant spoke about the presence of her family during her hospital stay. She had family members stay with her in the hospital, as well as during the visitation period. The participant continued by saying that her family presence made her feel; “Happy, very happy”….Because I wasn’t alone. My daughter loves me a lot.”

Again, another participant described the presence of her spouse as a source of physical and emotional support:

Well, because I had a C-section he helped me. Because when you use the call button the nurses don’t come right away, they take long….he was there with me helping me get up and taking me to the bathroom. If I had pain he would help me move, if the baby was hungry or if she pooped he would deal with her. But mostly, for company…he wanted to be there.”

Family members and friends provided emotional and physical support to participants. Their support provided participants with comfort, reassurance and security during the hospitalization.
Subtheme 4 - Organizational Support. Organizational is defined as, “An organized body of people with a particular purpose, especially a business, society, association.” (“Organizational”, 2015, para.1). Support is defined by Merriam-Webster as, “giving assistance or help, enabling to function or act” (“Support”, para.1, 2015). Participants provided accounts of hospital processes and protocols that were available to meet their language needs; herein defined as organizational support. This form of support contributed to four participants’ positive perceptions of care. The presence of interpreters, bilingual healthcare providers, patient educational or informational forms available in Spanish and the provision of assistance in the completion of paperwork were noted to provide participants with increased understanding of care, self-advocacy, emotional well-being and decreased reliance on others.

One participant provided a rich description of how the provision of language services during her hospitalization enhanced the quality of her care:

“In this hospital, for me is the best and has done me well. I’ve been to others but it was not good for me. In terms of the attention they are very good and I recommend it to anyone. I cannot speak any English, but they have the team of interpreters by phone or staff who help there…..first of all the attention of nurses and doctors. The care was excellent…

Due to having access to and frequently utilizing the available language services the participant noted that she no longer hesitated when requesting services during her complicated pregnancy and hospitalization. In describing the language services she utilized during her hospital stay and during the course of stay for her premature infant in the Neonatal Intensive Care Unit, the participant added the following comment:

I was fortunate that the gynecologist who saw me spoke Spanish….But there the nurses…they were translating and it was very easy as well….. they communicate by phone. One can ask the language and can communicate more quickly….but as one already loses fear I always asked that they explain in Spanish. And they would look for a translator or by telephone.

This limited English speaking participant also described the involvement of one interpreter
who had been assigned to provide language interpretation. The interpreter accompanied the participant to physician visits, during the surgery and hospitalization. The participant viewed the interpreter as an integral part of his care and someone he trusted, which contributed to his perception of a positive hospital experience:

She was an interpreter. She didn’t leave me alone at any moment. She followed my case. She would tell me: “this is happening, they are not doing this because this is a problem…” She explained everything to me. Even she was getting married and she told me: “I’m going to Spain, but when I return, that’s when you are having surgery.” When she came back everything was ready for the surgery and she continued working with me and on my case, helping me as the interpreter. I received a very good service.

A sense of well-being was noted as these two participants recalled how happy they were to be able to communicate with the healthcare providers who knew a few phrases in Spanish. For this participant, despite having constant family support that provided interpretation, communicating with the nurse directly in Spanish directly elicited a feeling of happiness. She explained, “Because I understood everything they said and knew my medicines. I thought: I’m going to get better. I felt happy.” For another participant, communicating with the nurse in Spanish; “Felt really good [Smiling], I could communicate and tell them what I needed if I was in pain.”

Lastly, an unconventional source of organizational support for patients was noted in the experience of a participant who was hospitalized for the birth of her child. Here she reflected on the support she received from the housekeeping staff or the “cleaning ladies” as a source of support. This group of women became an informal source of support after the participant complained about her care.

They treat the patients better than the nurses. They give you better information if you ask them. They tell you about this and that… But if instead you ask the nurses… there was one, a Hindu… when the baby didn’t stop crying because she was hungry and I didn’t have milk to breastfeed her, she grabbed my nipple and squeezed it hard… in a bad manner…

The participant was smiling when she spoke of the “cleaning ladies”, when the PI asked her about the smile, she noted:
Because they treat you well, with more love. They would ask: “how does the new mommy feel? So, they showed me more love. I felt good. Someone was concerned. Instead the other ones would come in and they would tell me: “did you call?” They wouldn’t say anything else and you feel things changing, you feel the difference. So, they (cleaning ladies) are nicer.

Acknowledgement as an individual and as a person who needs care is what this participant found valuable and appreciated from the housekeeping staff.

Finally, the service provided by the physicians was noted as several participants who spoke of the physicians as “good”. Two participants were explicit in identifying the skills of the physician as contributory to their positive experiences as patients as noted in the next two narratives.

But what can I tell you…I’m thankful to the hospital. The doctors treated me very well, the surgery was a success, that’s how they explained it to me, but I can also appreciate that. The two surgeries were successful, the first one with the kidney and the second one with the spine….

Here this participant recounted this story when describing her experience with the physicians. She noted the skill with which the physician performed an epidural;

The anesthesiologist was good. I had other deliveries at [another hospital] and I could tell the difference with this one… because over there [another hospital] they gave me anesthesia (an epidural) and it didn’t work. They made me bend over and with my big belly… This anesthesiologist was more professional. Just two little pricks… and I didn’t feel any pain.

Summary of Theme 2-Positive Experiences and Subthemes

Positive is defined as “A good, affirmative, or constructive quality or attribute” (“positive”, 2015, para.1). Experience is defined as, “An event or a series of events participated in or lived through” (Soukhanov, 1992, pg. 644). In this section, positive experiences are those events that the participants perceived were “bien” or “good” aspects of care or “good” behaviors of the healthcare provider. Several of the described accounts illuminated that the perceived skill competency and or how the behaviors of the providers affected the participant experiences. The theme of positive experiences along with the
subthemes of anticipating needs, attention, family support and organizational support were described above. Participants described many factors that contributed to perceived positive experiences in the hospital. Direct communication with healthcare providers was perceived to be important for non-English and limited English speaking participants; but the behaviors and skill of healthcare providers had the most impact on participants’ positive perceptions of care. Indications of good care, as perceived by participants, included being acknowledged and treated as an individual, receiving attention, healthcare providers anticipating and meeting their needs in a timely manner, and frequent monitoring. In terms of healthcare providers meeting and anticipating participants’ needs, they specifically mentioned the assessment and management of pain in a timely manner by the nurse as an indicator of good care. Non-verbal communication skills such as listening, and gentle touch, as well as, verbal communication skills and a calm voice exhibited by the nurses were described as caring and kindness.

Other factors that contributed to a positive hospital experience included the presence of family members who provided emotional support and language interpretation, and hospital protocols and processes that were implemented to meet the language needs of the participants. Bilingual healthcare providers, the utilization of interpreters in person or by phone, forms translated in Spanish and assistance in completing forms were noted as forms of hospital organizational support that enhanced the patient experience. As noted by one participant, the housekeeping staff provided emotional support, as well as information on the expected standard of care and how to engage with the nursing staff.

**Theme 4 - Negative Experiences**

Negative is defined as, “Marked by or exhibiting features, such as hostility, that cannot be deemed positive or constructive” (Soukhanov, 1992, pg. 1209). Many of the participants
described negative experiences as those in which they perceived care, mainly [nursing], to be “feo” (ugly) and “incomodo” (uncomfortable) “mal/malo” (bad). The emerged subthemes were delays in treatment, maltreatment, lack of respect, losses, personnel issues, family support and lack of organizational support.

**Subtheme 1-Delays in treatment.** According to The Joint Commission (2015), delays in treatment occur “when a patient does not get a treatment – whether it be a medication, lab test, physical therapy treatment, or any kind of treatment – that had been ordered for them in the time frame in which it was supposed to be delivered. “ (para., 1)…. This subtheme emerged as four participants described what was perceived to be long wait times after requests of care, which ranged from request for pain medication to assistance with bathing. As one participant noted; “Downstairs in the ER if I called them because I was thirsty it took hours before someone brought me a glass of water.” All of the participants perceived that the delays in treatment were also associated with perceived poor nursing care and or the nurses were seen as lacking empathy. As one participant noted, “The ‘not so good’ [nurses] are bitter…” In the following participant description, the delays in treatment for pain medication were further compounded by the perceived negative attitude and behavior of the nurse:

> When I am in a lot of pain and I use the call button because I need them to come, they tell me they’re coming, but fifteen minutes go by and they don’t come. So I have to call them again. When they come to the room they are hostile and complain about me. They keep me waiting for a long time and no… I wouldn’t recommend them to anybody.

This same participant continued to speaks about delays in transport:

> Another thing that has been bad during my experience has to do with transport services. That is really bad! When I have been hospitalized they take me down to dialysis and when I’m done they call transport to pick me up… After I’m finished with the dialysis they take up to an hour to get me. And I’m sitting there, hungry, waiting for someone to come with a wheelchair for me. Every time I go (for dialysis)… or I go to radiology they leave me waiting and waiting for a long time. That service is really bad.
The participant later stated that his complaints to the nurses and transport staff about this issue were not addressed. Similar delays in treatment and response to concerns were noted by another participant as she described what occurred after a family member realized that she had received the wrong baby from the nursery and waited for 2 hours before her infant was returned. In this accounting the nurse disregarded the participant’s concerns and demonstrated a lack of accountability for this patient safety error:

A nurse from the nursery came in pushing a stroller where they carry babies around and she said: here’s your baby…. But my brother-in-law was very curious and he went to look at the baby. He said: “this baby girl is not yours.” Then he (brother-in-law) went to the nurse’s station to let them know about what had happened. A nurse talked to him and said that she was assigned to work with me only, that the baby had a different nurse. She told him to go the nursery and look for the baby’s nurse…..

Below another participant revealed that she attributed the delay in treatment to the nurses not wanting to provide care at all:

My babies have been delivered by C-section and when you have a C-section you’re supposed to get pain medicine. I would ask for my medicine and sometimes they wouldn’t give it to me. So, honestly, we felt they didn’t want to give us good care.

The accounts of these participants revealed that delays in receiving treatment for these 4 participants resulted in delayed pain management and emotional distress.

Subtheme 2 – Maltreatment. Maltreatment, as defined by Merriam-Webster as “treating one rough or cruelly” is discussed here (“Maltreatment”, para., 2015). This subtheme emerged as three participants described experiences in which they called the treatment “bad”. Below a participant hospitalized in the intensive care unit (ICU) described an argument with the nurse that occurred after his request for a bedpan was denied. The participant stated that this encounter occurred with both him and the nurse speaking English:

Only once I had a very ugly fight when I was in the hospital. …. A nurse was very bad… I asked for the bedpan…but she didn’t bring it. I called her, she came in, and she told me I could reach out and get it. I said: “so why are you here? If I could do it myself I would go there (bathroom), but I can’t. I’m weak.” Later she came back really upset and asked me: “what do you want?” She said that if I didn’t like the way she spoke to me why didn’t I leave? I said if I could I would leave. I said: “you know
what? I don’t need you, but I need to speak with your manager or a supervisor.” So, she closed the glass door and it was really hot in the room. There was no air conditioning. Very ugly…very ugly there. I felt she wanted me to suffocate in the room.

The refusal of the nurse to assist the participant was further compounded by the nurse speaking to him in an argumentative manner and demonstrated unprofessional behavior. Further, he perceived the nurse’s actions of closing the door to be an act of retribution and left the participant feeling vulnerable. By reporting the nurse, the participant asserted his right to receive the standard of care.

Inconsistent treatment and not knowing what to expect contributed to participants’ perceptions of maltreatment and dissatisfaction with care. For example, one participant recounted that she sought treatment in the emergency department several times in a 2-year period for spontaneous abortions and bleeding during her pregnancy prior to finding proper treatment, and being placed on bed rest and later hospitalized. The participant’s lack of information, inability to understand, feeling isolated and not being seen in a timely manner contributed to her perception of bad treatment. Below is her accounting of her experience in the emergency department:

I arrived bleeding and with strong pain. I was eight weeks pregnant and it was midnight and then it was 6 o’clock in the morning and no one attended to me. It is traumatic when this is the first pregnancy, one does not understand anything and I cannot speak English. Nobody answered me. No one told me what happens or we are going to see you soon to see if you kept the baby or if something else that’s passing. As I say it was very bad experience there.

Another participant who reported receiving treatment at a hospital and receiving “good” care two years prior recounted what she now described as a negative experience during a recent hospitalization at the same hospital. “This time around it was very, very bad… from the moment I stepped in. Not when I was in the ER, but after I had the baby.” The participant’s negative perceptions of her care were based on comparisons drawn from her previous hospitalizations, delayed response to requests, lack of regard for the participant’s
assessment of the baby and the perceived inadequate response to the needs of the baby. From this, the participant determined that the nurses were intentionally withholding care.

Additionally, the participant distrusted the nurse’s judgment on what the baby needed:

The next morning, my baby cried of hunger and my husband asked the nurse for a bottle, but she told him that I had to try to breastfeed the baby. I tried, but I had no milk, nothing. She gave him (husband) baby formula, but the baby continued to cry of hunger. She told him she couldn’t give us anymore because newborn babies eat very little. ... My husband told her the baby is hungry, but the nurse told him “no” maybe the baby is cold, it could be her diaper, or maybe she is in pain. I don’t know… I don’t think that was a good answer because right after that another nurse, a very nice one, stopped by and I asked her for milk and she gave us formula, and the baby drank the whole bottle.

Subtheme 3 - Lack of respect. When two participants spoke of their negative experiences, the word “respect” or “respeto” was referenced. Three definitions are used here to describe this subtheme. In Hispanic culture, “respeto” is a word which typically describes a cultural norm; a set of non-verbal behaviors or verbal skills used to demonstrate deference or regard for an individual (Dayer-Berenson, 2014). But, the English definition to 1) “Avoid harming or interfering with and 2) Agree to recognize and abide by (a legal requirement)” (‘Respect’, para.1, 2015) is also relevant to this theme. Lack is defined as, “To be entirely without or have very little of”; (Soukhanov, 1992, pg. 1005). Through the descriptions, participants not only recognized respect as an essential value, but described respect in various ways. When speaking of nursing care, this participant described respect as demonstrating caring and empathy as necessary components of providing care to patients and the absence of that respect was considered unfair:

Something…. I think they should do their job respectfully, right? …with love. When you are in the hospital is when you need a little more love. One is depressed, tired, mainly in pain…. And if someone comes in and is rude…no. I don’t think it’s fair. I don’t know.

The next participant further clarified what was meant by “giving respect”. For this participant, respect was operationalized as providing the standard of care and addressing
concerns in a timely fashion for all patients:

I mean with respect, to not play with one’s health which is very big. You go to the hospital because you need it. One needs to treat you and to respect it in that regard.

Further, the participant provided a more specific example of what respect meant:

When I went to that [hospital] I was referred here [clinic]. I happened to know that I was bleeding. And I was afraid of losing another baby, I didn't want to. I was not comfortable with the [lack of] attention. I wanted care...every patient deserves respect. One deserves the attention at the moment and for one to meet your needs. And there when they came to see me, my biggest concern was that I was bleeding.

Participants viewed respect as a necessary component of care that they did not receive.

In addition, participants described healthcare providers as demonstrating respect when the provider was empathetic and attentive to the participants’ needs.

**Subtheme 4 – Losses.** Two participants shared stories of loss. Loss, according to Merriam-Webster is defined as the “act of losing possession and the harm or privation resulting from loss and separation” (“Loss”, para.1, 2015). These narratives provided examples of the negative impact that language discordance can have on health and financial outcomes. Because of language barriers, one of the participants was not able to understand her health issues and seek appropriate treatment in a timely manner to prevent the complications of her pregnancies, which according to the participant, resulted in two spontaneous abortions, the possible premature birth of her daughter and the loss of her job. The participant stated this as it had been explained to her by the physician regarding the birth of her daughter; “But then if I had been treated with cerclage from the beginning, my baby would not be born premature. There was a possibility. I don’t how to explain.” She recounted losing her job:

They said bed rest. I had to stay in the house. I was working at the time. I got a letter saying that I could not return to work for one week, until that date I could not return to work. I lost my job. It was another trauma to me. When one loses work, you stress.
For the other participant the inability to understand English resulted in loss of financial aid for health insurance; “For example, I requested Medicaid assistance ...(unintelligible) and they helped me pay Medicaid expenses, which was about $419 every three months. They sent me a letter saying I had to renew the application, but I didn’t understand because I can’t read in English…” Although the participant was able to speak “some” English, he was unable to read and understand the letter written in English. The participant further explained that he did not always understand discharge instructions written in English and when available he used an interpreter.
Subtheme 5 - Personnel Issues. Personnel, is defined as “the body of persons employed by an organization” (Soukhanov, 1992, pg. 1352). Throughout this study, all participants spoke about the caregiving behaviors of nurses. As participants spoke of the nursing care, they reflected on the perceived failures in care and possible causes for those failures. Here, participants’ shared perspectives about nurses as employees and nursing as a job. Staffing problems, nursing job satisfaction, fitness for role and reporting poor nursing care to supervisors were discussed. Two participants shared their thoughts on the overall job performance of nurses as employees. Interestingly, the participant reported that both he and his wife had recently been hospitalized. While he described his nursing care was excellent, he stated that his wife did not have a similar experience. He expressed concern over not being able to take his wife home as she requested, “It made me sad because I couldn’t do anything. I couldn’t get her out of there because it was risky.” Offering a possible explanation for the care his wife received, he made this observation about nurses: “… I think sometimes you can see their attitude…. you don’t know if they are not comfortable with their job or they are being treated badly. We have to analyze all those things… But I would say that when an employee is not comfortable working, don’t do any harm.” This sentiment was echoed by another participant who stated: “I think they should fix personnel issues, especially those related to the poor treatment of patients.” Both participants held the view that providing poor nursing care should not be allowed or accepted and that nurses who perform poorly should be evaluated: “It’s like in any other place, in the hospital, there are people working and their bosses don’t see if the employee is interested in the job; corrective action taken and provided the opportunity to improve…maybe not fire them, but have a meeting to talk about doing a good job.”

Three participants noted issues with nurse staffing. Two of the three participants perceived that staffing was inadequate and may have contributed to their poor care, as one
participant recounted: “Maybe it was either the day or the hour indicated because that day I was not well attended. Perhaps it was not... maybe they were sleepy, bored. I do not know.”

Another participant relayed her encounter with a nurse in which the participant perceived the care to be inadequate. Poor staffing was cited as the reason for poor treatment:

> When I finally saw her attitude, the expression on her face, and her unwillingness to do stuff, I asked her if she had a problem? She told me they were short in staff and that all women had decided to deliver their babies at the same time. That happened with the nurse in the night shift.”

Two of the three participants perceived that the care provided during the day was better than care provided during the nightshift. Both participants viewed nurses on the dayshift as better at anticipating needs, as one participant recounted, “Instead in the morning they would ask: ‘are you feeling ok, do you need medicine, or do you have any pain?’ They would also ask I needed anything else.” Further, the participant recounted that she managed her needs to accommodate the differences in staffing; “I would ask for stuff so I had everything in the afternoon and I didn’t have to ask for anything.” The other participant recounted how he had difficulty with the nurses on the nightshift and made this comparison to the dayshift: “The nurses from the first shift…Wow! They were very good!” Interestingly, another participant who perceived his nursing care as “good”, also noted differences between the shifts and offered the following explanation:

> Well, in the evening one is resting and they are not supposed to come in a lot. Only in case one needs anything, you call them. The day shift nurse is more attentive. She would be coming in and out…

Finally, reporting incidents of poor care was a point of discussion for three of the participants. While all three had experienced what they perceived to be “bad” treatment or care by the nurses, all three had very different approaches in how they responded. In this first narrative a limited English speaking participant demanded that he be assigned to another nurse after perceived maltreatment while in the ICU. The participant viewed filing a
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complaint as his right as a patient and as a person who is paying for a service. He recounted his encounter with the charge nurse with them speaking English:

Later on a supervisor came in. She was dressed in white or grey. I told her “I didn’t want the other nurse taking care of me…She’s upset and she doesn’t want to do what I need her to do. I said: “this service is very bad.” I have to pay for insurance and the service you’re giving me is bad.” I said: “that’s not fair, it’s not fair.” So, she sent another nurse. And I’m not going to lie she was very good.

Another participant also reported the poor care she received. Although this participant and her spouse were dissatisfied and upset with the care they received and had strongly advocated for their needs during the hospitalization, the participant was initially reluctant to complete the survey administered at discharge stating, “I asked them if I should answer it and they told me it was my right to answer.” The completion of the survey prompted a follow-up visit from the charge nurse prior to the patient’s discharge and a phone call by the unit manager after the participant was discharged. The participant reported that both the charge nurse and unit manager apologized to the participant, “They apologized again. They said they had realized they had problems with the night shift staff. ‘A job is a job and the night shift nurses have to treat you well regardless.’” While the apology provided some comfort to the participant, it did not fully resolve the emotional upset she felt as noted below:

Well, during my hospital stay I felt really bad because my husband had an argument with one of the nurses, but when I was discharged I thanked God. Then when the charge nurse came by…and she apologized for the inconvenience… I told her it was ok, what else could we do? When she apologized I felt good. But honestly…[participant shrugging her shoulders]

Lastly, this limited English speaking participant spoke about the nurse who made the error of giving her the wrong baby and why she did not report the incident:

I thought of so many children they deal with… I imagine it can be stressful when they cry. Other people who came to visit me suggested I complain and report her. I said no because we all need to work and maybe mistakes happen because you may have a problem or you’re distracted… For a little thing like that have her lose her job… I don’t know. I don’t know if she’s a single mother or if she has any other commitments… and for a complaint have her lose her job… Also, who knows how long has she worked there… I don’t know.
She continued later:

I feel that I received good care at the hospital. However, sometimes maybe have someone… Maybe they need to be more careful. You see what happened to me when I had my baby… Maybe (You) can be more careful and more vigilant when dealing with baby names. Also, maybe double-check the baby name and if they are taking the baby to the right room… things like that.”

It is interesting that this participant despite being very upset initially, considered the error “a little thing” later. She seemed to have gained a different perspective on what occurred and the consequences to the nurse. This participant considered multiple variables, the nurse as a mother, a person who needs to make a living.

**Subtheme 6 –Family Support.** Here family is defined broadly as “All the members of the household under one roof” (Soukhanov, 1992 pg. 659) and “The adoption of non-relatives into kin-like relationships” (Isben & Klobus, 1972, pg. 615). Support is defined here as, “To promote the interests or cause of; to uphold or defend as valid or right or to advocate or to argue or vote for” (“Support”, 2015, para.1). Four participants described the roles of their family members in their accounts of their negative experiences. As in the accounts of positive experiences, family members continued to provide emotional support to participants and language interpretation during these encounters. However, when participants described situations in which they perceived poor or inadequate treatment, the family member often was also described as being a patient advocate.

This participant spoke about not wanting her husband to leave to find her something to eat after she spent six hours in the emergency department, experienced a drop in blood pressure and waited for a dilation and curettage after a miscarriage. The participant was concerned about them being separated and was reliant on him for emotional support.

Yes. He could not leave. He is like me and does not speak English and could not then leave to go outside to find something because then he would not get back in. He tried to leave out and but he wouldn’t be allowed back in. I mean security, which in one
aspect is good, but I was his wife and was in. And he could not leave because if he did he could not enter again.

Several months later, this participant returned to the emergency department for vaginal bleeding while pregnant. She did not have an understanding of the health problem due to the inability to communicate with the healthcare team stating, “I ask and ask what was it that I had. I needed to know what the problem was…Then I had the same problem of not being able to speak English.” She eventually returned to the emergency department with a family member who “speaks English well” to be evaluated for bleeding. The reliance on her cousin to interpret allowed her to have relief and some understanding of what caused the bleeding. Having this information allowed her to seek help outside of the hospital. “I was told only that hormones are decreased. But I understood and I’m not a very good student, but when one’s hormones are decreased there is treatment, they need to see if they will rise slightly or be instructed one how to do.” Through a co-worker’s referral, the participant was later able to find a specialist and seek treatment.

Family support and advocacy were seen here as this participant discussed her husband remaining with her throughout the hospital stay to assist her and the baby. “Because when you use the call button the nurses don’t come right away, they take long. But mostly for company; he wanted to be there.” The husband became the participant’s advocate as he became concerned about the perceived poor management of the participant’s pain and an argument ensued with one of the nurses. “Because he saw no one was taking good care of us…my babies have been delivered by C-section and…you’re supposed to get pain medicine. I would ask for my medicine and sometimes they wouldn’t give it to me. So, honestly, we felt they didn’t want to give us good care.”

In this next exemplar, this non-English speaking participant’s adult children were language interpreters and patient advocates during a 36-hour stay in the emergency department and 12 hours on a medical-surgical unit. The participant spoke about how his
family supported him. His daughter-in-law served as an interpreter: “She followed the ambulance and when I was admitted to the ER she was there. She speaks English well. She gave my personal information and she was there with me when the doctor came to examine me, she was there translating. While still in the emergency department, the participant’s son intervened as a patient advocate, “….. For example, I hadn’t had a drink of water all day. I asked the nurses for water, but they ignored me. My son went to see me and got me water. When I asked for water they would bring me a small glass and being diabetic one drinks a lot of water.” The participant further explained how he relied on his son to provide interpretation; “When my son came to visit me, I would take advantage to communicate with the doctor. The doctor went to see me upon arrival, later another visit…. Three visits… Twice in the ER and one upstairs.” Note that the participant used the phrasing “take advantage,” which denotes a reliance on his son to assist him and that the language support he needed was not available to him.

This non-English speaking participant, who stated that overall her care, was “good”, spoke about this “bad” experience and how her husband intervened:

……there was a nurse that wasn’t very attentive. I felt bad because you bleed a lot after [delivering the baby] and she didn’t show up until the baby’s father went looking for her. But then she came in and helped me.
Subtheme 7- Lack of Organizational Support. Lack is defined as, “To be entirely without or have very little of”; (Soukhanov, 1992, pg. 1005). Therefore in this subtheme, a lack of available hospital processes and protocols to meet the language needs of participants contributed to the participants’ negative perceptions of care. Three participants described lack of knowing or understanding about their health concerns or course of treatment. The inconsistent utilization of interpreters, the absence of bilingual healthcare providers, forms unavailable in Spanish and the lack of assistance in the completion of paperwork were noted in the following accounts.

The participant was illiterate in Spanish and English and required assistance in completing the Social Security forms and birth certificate for her daughter. She spoke with frustration as she discussed the absence of the assistance during this hospitalization, when it had it been previously been provided at another hospital:

For example, at [hospital A] when they gave me the paperwork for the Social Security and the birth certificate for my daughter, no one helped me….You know that I don’t read or write in English or Spanish. So I didn’t know how to fill out the forms. But when I was at [hospital B], I always had someone who spoke Spanish and helped me and explained things to me.

The participant who relied heavily on his son and daughter-in-law for interpretation during his stay in the hospital stated the following regarding the absence of interpreters:

Well, my experiences in other hospitals like at [Hospital A], there’s always someone who speaks Spanish and you are required to bring an interpreter. So you call a number, and sometimes they are not available and can’t come with you. But I know they always have them [interpreters] because I have gone and they’ve asked me: “where’s the interpreter?” And you say: “I called and I don’t have one” and they find one for you……Yes, also at [Hospital B] where I took my wife once.

He further added why he preferred to have interpreters:

Oh yes! Because you can trust them, you can tell them: “tell this to the doctor.” That’s why they are there to help us.
It was important for this participant to be able to advocate for himself through the interpreter. He was not able to do that while in the emergency room and this contributed to his negative perceptions of care.

**Summary of Theme 4-Negative Experiences and Subthemes**

In this section, the negative experiences and seven subthemes: delays in treatment, maltreatment, lack of respect, losses, personnel issues, family support and lack of organizational support, are discussed. Participants described several factors that contributed to their negative experiences. Non-English and limited English speaking participants reported delays in treatment, maltreatment and loss of respect as factors that contributed most to their negative perceptions. Delays in treatment ranged from slow response time in providing pain medications to delays in transport. The delays in treatment were further compounded by the perceived negative attitude and behavior of the nurse and their failure to address patients’ concerns.

Maltreatment emerged as participants described encounters in which treatment was not given, needs were not addressed or information was not shared. The participants’ lack of information, inability to understand feeling isolated and not being seen in a timely manner contributed to the participants’ perceptions of bad treatment.

The participants’ negative perceptions of care were based on comparisons drawn with previous hospitalizations and the nurses’ behaviors, facial expressions, delayed responses to requests, all of which resulted in distrust of the nurses’ judgment.

When participants spoke of their negative experiences, the word “respect” was referenced. Through the descriptions, participants not only recognized respect as an essential element of a patient-provider relationship, but also described respect in various ways. Respect was defined as providing a standard of care, listening and addressing concerns. Throughout
this study, the participants’ perceptions of the importance of the role of the nurse as a caregiver were evident. In this subtheme participants shared their perspectives about nurses as employees and nursing as a job. Staffing issues, nursing job satisfaction, and reporting poor care were discussed. Participants noted that nurses need guidance and should have accountability for poor job performance. Of those participants who had negative experiences, only three reported those incidents of perceived substandard care to a nursing supervisor. All three of these participants were limited English speaking and have had varied experiences with the healthcare system or hospitalizations.

As in the accounts of positive experiences, family members continued to provide emotional support to participants and language interpretation during these encounters. However, when participants described situations in which they perceived poor or inadequate treatment, the family member often was described as being a patient advocate. Participants’ accounts also highlighted that poor health literacy and language discordance contributed to poor health and financial outcomes.

**Theme 5 – Emotional Responses to Negative Experiences Individual**

Participants described varied physical and emotional reactions to the perceived negative experiences. Five subthemes comprise this theme: anger, discomfort, fear/apprehension, powerlessness and stress.
Subtheme 1 – Anger. Anger is defined as, “a strong feeling of displeasure or hostility” (Soukhanov, 1992, pg. 70). Two participants described anger in reaction to the care they received. The lack of education and blaming the participant for not following directions angered the first participant. “.....before I left [the hospital] the nurses told me that I didn’t use the bottles that they left in the bathroom for me to clean the wound. I was upset and angry at the nurses. They never told me anything. No. I was too upset and I just wanted to leave. I just cried.” Additionally, the participant was frustrated when she did not receive the assistance in completing the paperwork for her daughter.

Up to this point of the interview, this participant’s answers were short, her speaking volume was low and she did not make much eye contact with the interviewer or the interpreter. However, as the participant shared her story, her facial expressions and tone changed. With tensed lips, direct eye contact and animated voice, she spoke about how angry she was at the nurses. The response may have been worsened by the participant’s feelings of being in the hospital; “I felt depressed and sad. I don’t like being in the hospital. I don’t like being in closed spaces.”

The next participant was angered by the treatment he received during his hospitalizations. “When I’m in good condition or I’m not in a lot of pain I tell them. I get upset with them and I tell them that the service they’re providing is bad.” His anger was heard in his voice as he recounted the exchange between him and a nurse, “I ask them: ‘why are you working here?’ She said that if I didn’t like the way she spoke to me why didn’t I leave? I said: ‘If I could I would leave.’ I said: ‘you know what? I don’t need you, but I need to speak with your manager or a supervisor.” What the participant described here is his anger for being disregarded. In this instance, he used the anger and turned it into action by reporting the nurse. Similar to the previous participant, this participant also seemed to relive the emotion by visibly appearing to be angry as he retold his story.
Subtheme 2 – Discomfort. In this subtheme, two words are defined. First, discomfort is defined as, “mental or bodily distress” (Soukhanov, 1992, pg. 531). Uncomfortable is defined as, “experiencing physical discomfort or feeling ill at ease; uneasy or causing anxiety; disquieting” (Soukhanov, 1992 pg. 1943). This subtheme emerged as two participants described their experiences using the word “incomodo” (uncomfortable). In their narratives, physical, emotional and environmental descriptions of discomfort were provided. The first participant described her treatment in the Emergency Department in which she described physical pain and the emotional discomfort of poor treatment:

Six hours [I had] non-stop bleeding and I could not tolerate the pain…So all I got was sanitary towels to contain the blood but that is no help. But I needed to be checked urgently. And when they finally came to check on me, they told me that there was no baby, which had probably been (unintelligible) in the bathroom. That is very ugly for one to be treated. It feels very uncomfortable.

The next participant also described physical discomfort from being in pain and a feeling of discomfort from receiving inadequate care. This participant provided this physical description of discomfort as sleep deprivation and noise overload which resulted in the participant feeling anxious:

Well, my experience was… I was very uncomfortable one evening and all day the following day because the way I was feeling…. The nurses took me where they take emergency patients. They left me there all day and all evening. I couldn’t sleep at all because there was too much noise… the nurses…They were telling jokes, speaking loudly…So, around 10 pm [36 hours later] I was demanding sleep medicine because I was anxious. When I asked for the medicine, the nurse told me that they were going to transfer me… I understood ‘transfer’ and soon after they brought in a bed, a more comfortable bed, and they took me to a room.

The participant then compared and contrasted the environment in the emergency department with the room on the medical-surgical unit; which highlighted the discomfort he experienced in the Emergency Department; “Yes, everything was better. Even the bed table worked well. Downstairs the table didn’t work well. You couldn’t raise it or lower it. Nothing worked on the bed. That bed was ready to be trashed.”
**Subtheme 3 – Fear and Apprehension**

Fear is defined as “a feeling of disquiet and apprehension” (Soukhanov, 1992, pg. 667). Apprehension is defined as a “fearful or uneasy anticipation of the future, dread” (Soukhanov, 1992, pg. 90). These feelings that something bad will happen, emerged as this subtheme emerged as three participants described their reactions to their treatment. After having a negative experience in the emergency department that resulted in a spontaneous abortion, this participant spoke of the apprehension she felt toward that hospital, “I never wanted to return. I will never return to that hospital.”

Another participant spoke of her feelings of fear when she realized that she had been given the wrong baby for 2 hours, “I was afraid. I thought that if they don’t realize… they can steal her… or can you imagine if they take the wrong baby? That happens sometimes in the hospital…..” The participant went on to say that at times, she wonders if her baby had been breastfed by another woman.

Lastly, a participant who has had multiple hospitalizations stated that when he requires hospitalization, he has concerns about the nursing care, “The only thing I think about when I go to the hospital is ‘which nurse am I going to get today? A bad one… a good one?’ That’s the only thought I have… They make a difference.” The participant also spoke of being more aware, “The difference is that I notice the bad things.”

**Subtheme 4 – Powerlessness.** Powerlessness, the feeling of “lacking authority or the capacity to act” (Soukhanov, 1992, pg.1420), is described here as two participants recounted negative experiences. The first participant described accepting an apology after receiving what she described as “very, very bad care”. The powerlessness she felt is noted in her statement, “I told her it was ok, what else could we do?” She further explained:

….but when I was discharged I thanked God. Then when the charge nurse came by, by the way her name is (Maria, a pseudonym), and she apologized for the
inconvenience… I told her it was ok, what else could we do? When she apologized I felt good. But honestly…

As the next participant reflected on his situation, he appeared solemn as he described losing his financial assistance. Powerlessness was reflected in his facial expressions and tone of voice stating, “I felt very bad. I picked up the letters, but I didn’t know it was the renewal application. I also asked someone to help me fill out the forms because I just know how to sign my name.” In recounting his story, the participant appeared sad as he talked about losing the benefit and having to rely on someone else to complete the form. “So, I had to find someone to help me fill out the form after they sent it in Spanish.” The inability to read and write in English contributed to his feelings of powerlessness.

Subtheme 5 – Stress. Hospitalizations and alterations in health can cause mental and physiologic stress. Merriam-Webster defined stress as “a constraining force or influence as a physical, chemical, or emotional factor that causes bodily or mental tension and may be a factor in disease causation or as a state resulting from a stress: one of bodily or mental tension resulting from factors that tend to alter an existent equilibrium.” (“Stress”, para.1, 2015). Two participants discussed the impact of stress on their well-being.

After multiple emergency room visits and two miscarriages, a participant was placed on bed rest to prevent another miscarriage and, as a result, lost her job. The participant described the response to her loss this way: “It was another trauma to me. When one loses work, you stress.”

After experiencing a recent hospitalization in which a participant perceived receiving substandard care, she described the possible role that stress may have had on her inability to breastfeed. She reflects on her past hospital stay and compares it to this most recent experience. “Well, if we compare it with the first baby, they treated me excellent and I was able to breastfeed right away… in the hospital. I put the baby on the breast, he sucked, and
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milk came down. So I know that perhaps stress had something to do with it…I don’t know. Maybe I felt bad because the milk didn’t come down… I don’t know.”

Summary of Theme 5-Negative Responses - Emotions and Subthemes

Unlike the feelings of peace, calm or happiness that were elicited in participants with positive experiences, participants who had negative experiences had a range of emotional responses. Lack of timely treatment and perceived disrespect led the participants to experience feelings of anger, sadness, powerlessness, physical and financial loss, and physical and emotional stress.

Theme 6 - Healthcare system and fairness, equality and just care

In this theme, nine of 11 participants spoke to the concept of everyone receiving or deserving to receive care that is without bias or discrimination in the U.S. healthcare system. Overall, the perceptions were positive as the system was largely seen as fair and equitable.

Seven of the participants perceived the overall healthcare system in the U.S. to be very good despite their negative hospital experiences. Four of the seven participants were non-English speaking, while three were limited English speaking. Only one of the participants had more than one hospitalization in the last six months.

The other two participants proffered a more complex perspective of the U.S. healthcare system. One of the participants who reported having a positive hospital experience, perceived the healthcare system to be a “little bad”. While, the other participant who described having a negative hospital experience also perceived the healthcare system to be unequal. Both participants were limited English speaking and reported having multiple and varied healthcare experiences in the U.S. The following are the perceptions of the nine participants about the U.S. healthcare system.

Six participants spoke of their perceptions of fairness and equality within the U.S.
healthcare system. One participant recounted, “I think it is very good. They treat you well here…. During pregnancy they check that you are doing well, that the baby is doing well… Here and anywhere else in the U.S… because they treat everyone the way they treated me.”

Another perspective added by a participant was that the healthcare system provided her with access to healthcare and social services: “They are very good because they cared for me. They gave me medicines and food…they even gave me food stamps.”

Other participants spoke of the perceived equity in healthcare in the U.S. juxtaposed against the perceived inequities in healthcare in their country of origin, “It was good… especially, when compared to the health care system in Honduras.” This participant focused on the caring behaviors of nurses as a measure of the healthcare system: “I think it’s good. If we compare it to our countries they [nurses] are rude and the treatment is very bad. There is more kindness here.”

The following description from another participant pointed to the lack of healthcare access and support for the poor in her country and the perceived support provided to the poor in the U.S.:

Because here if you get sick or you need surgery, you can go to the hospital and they will attend to your needs. They don’t ask if you have papers or not, if you work or not, or how are you going to pay? They take care of you. …….Here, after being discharged you can make arrangements with the hospital to pay, if you can’t pay you apply for assistance that helps cover the costs. They don’t let you die here. In my country accessing health care is more difficult.

Echoing this sentiment, this next participant provided a rich description of healthcare in his country. He noted the perceived age discrimination, lack of individualized care and lack of organization/institutional resources and support: “… the situation here is much better than in my country. It’s really hard in my country because of the economic situation.”

It’s a thousand times better than in my country. It’s good, very good. First of all, here, to take care of you they don’t look at your age. In my country, they don’t pay too much attention to older people like me…. For example, I’m a diabetic and we all get the same medicine, right? If you are a diabetic the same, if you have high blood pressure, the same: Lisinopril. It has another name there: Enalapril. The hospitals
are… honestly you die of desperation.

He added:

Yes, there’s no air conditioning or a fan, if you want to be comfortable your family has to bring stuff from home. If I want to take a shower I have to bring my own soap, my own toilet paper, everything. I was hospitalized in one occasion and there were not bed sheets on the beds, not a blanket….Yes, your skin sticks to the plastic… It’s hard.

These participants’ accounts highlighted their perceptions that the common values exhibited in the U.S. healthcare system are fairness and being just. Further, their perceptions of the U.S. system were influenced by their experiences in their countries of origin.

On the other hand, two of the participants spoke of flaws they identified within the U.S. healthcare system. This participant’s account highlighted the role of media in shaping his perception of healthcare in the U.S., which he stated was a “little bad”. He described an undercover reporter investigating problems in the hospital.

Well, I say that because there have been problems, problems you see on TV… Things have been revealed and they can say “ok, let’s see what we can do.” It’s good because is possible things can be corrected. For example, if a hospital has made mistakes, like the ones we have talked about here…

Additionally, the participant perceived inequalities in the healthcare system as he discussed the issue of illegal immigration within the context of healthcare. He recounted that although he had not directly faced discrimination, “I as a Puerto Rican, have all the rights”, he is concerned about the healthcare experiences of undocumented persons. Here the participant highlighted the fear that undocumented persons may experience in seeking healthcare and the possible physical harm that could result from delayed treatment. Further, the participant viewed healthcare access as a basic human right; “We are human beings and everybody has rights. It’s a shame when someone dies because they refused to go to the hospital.” Lastly, the participant noted the importance of not viewing Hispanics as a monolithic group, but as a diverse group with varied experiences: “the person who crosses the mountain and who comes here looking to feed his children…They need help, but when
they land here they realize that is impossible. They try to find a way to work… but there’s the
bad person trying to harm… The one who is bad is bad… and they know who that is. Take
him away! But not all of us are the same.”

Lastly, perceived inequalities in care provided across geographic locations and clinical
settings were noted in this participant’s narrative:

Four years ago I lived in New York City and everything related to medicine is
excellent there. From the moment women go to deliver their babies at the hospital to
when they start taking their children to the clinic… it’s all very good. Here, the clinic
…. is good. Excellent and I would recommend it, but the hospital…not very good.

The participants’ description highlighted that perceptions of care can be influenced by
different experiences with the U.S. healthcare system.

**Exhaustive Description**

Conducted in the hermeneutic phenomenological tradition, this study explored the lived
experience of non-English speaking and limited English speaking Hispanic patients who had
been hospitalized. The following is an exhaustive description of the participants’
experiences.

Participants described a complex picture of their experiences as patients. The
participants’ perceptions of care were based on their recent hospitalization and comparisons
from previous hospitalizations in the U.S. to hospital experiences in their country of origin.

Communication was the foundation of their experiences and affected the participants’
ability to express their needs, understand their diagnoses and to gain access to healthcare.

Participants described different methods to communicate with healthcare providers and
hospital staff during their hospital stays. Hospital-provided interpreters, language lines and
bilingual healthcare providers were available to some participants, but were not consistently
used throughout their stay. Additionally, materials written in Spanish were also infrequently
used. Some participants were given materials in English, despite their inability to read or
speak English. All of the participants preferred to speak Spanish while they were in the hospital for different reasons. Some participants described a lack of energy or being too ill to speak English, while others were concerned about missing information or details of their care. For the aforementioned reasons, participants considered interpreters to be trusted individuals who were integral to their care and their use was seen as a safety measure to prevent medication errors and medical mistakes. When interpreters were not available, some participants relied on fragmented Spanish or English and body language when bilingual speaking family members and friends were unavailable to help with interpretation. Several participants recognized the importance of speaking English and believed that it was the responsibility of the healthcare provider and participant to ensure care is given and received in a safe and effective manner.

Participants spoke about the events or encounters during their hospital stay that they considered “good”. While participants believed language concordance with healthcare providers to be important; it was the behaviors and skill of healthcare providers that had the most impact on their positive perceptions of care. Participants referred to nurses as “kind and caring” when they acknowledged the participants as an individuals, gave attention, and provided frequent monitoring, and attempted to anticipate and meet their needs in a timely manner. Several participants noted that the “nice nurses” displayed empathy, listened, used a calm voice and gentle touch. Another factor that contributed to participants’ positive perception with their care is the support received from their families or the hospital. The presence of family members and friends provided a form of emotional support to the participants, as well as, a trusted person for language interpretation. Hospital protocols and processes that were implemented to meet the language needs of the participants allowed the patients to express concerns and maintain autonomy.
Conversely, participants spoke about their experiences that they considered negative or “bad”. These narratives also provided examples of the negative impact that language discordance can have on health and financial outcomes. Some participants spoke of delays in treatment, maltreatment, lack of information and lack of respect from healthcare providers, which contributed to their negative perceptions. The delays in treatment were further compounded by the perceived negative attitude and behavior of the nurse and their failure to address participants’ concerns. Through the descriptions, participants not only recognized respect as an essential element of a patient-provider relationship, but also described respect in various ways. Respect was defined by the participants as providing quality care, listening to them, and addressing concerns. As in the accounts of positive experiences, family members continued to provide emotional support to participants and language interpretation during these encounters. However, when participants described situations in which they perceived poor or inadequate treatment, the family member often was described as being a patient advocate.

Participants shared their perspectives about nurses as employees and nursing as a job. Some of the participants believed that staffing problems, nursing job satisfaction, fitness for role of the nurse had a negative effect on their care. Several participants spoke to experiencing differences in quality of nursing care when moved from one unit to another in the same hospital or differences in quality of nursing care from day shift to night shift. Participants noted that nurses who performed poorly needed guidance, additional training and should be held accountable to prevent harm to patients.

The majority of the participants, regardless of age, language ability, education or years in the country held a positive view of the U.S. healthcare system. Several participants drew comparisons of the care they received to care received in their countries of origin, in which they described age discrimination, decreased access to care, and substandard conditions and
care. For these participants, they perceived the U.S. healthcare system as providing quality, just and equitable care. Conversely, one participant described the distrust and perceived discrimination some Hispanics, in particular, undocumented persons have experienced within the system. Areas of suggested improvement to the healthcare system included patient safety and language services.

Chapter Summary

In this study, the lived experiences of non-English speaking and limited English speaking patients in hospitalized in the U.S. were explored using the hermeneutical interpretative process. Participants described a hospital experience that was complex, as the majority of the participants described both negative and positive experiences during their hospitalization. From 11 participant interviews, a rich description of the phenomenon emerged and resulted in six themes with subthemes and an exhaustive description. In the next chapter, a discussion of the findings is provided along with the implications for research, education and practice.
CHAPTER V: Discussion of Findings and Implications

This interpretive phenomenological study explored the lived experience of 11 NEP and LEP patients of Hispanic origin. In this chapter, the NEP and LEP patient experience is discussed with reference to the literature. The limitations of the study, implications for nursing education and nursing practice, and recommendations for future nursing research are presented.

The Hospital Experience

In the U.S., a fundamental right during a healthcare encounter is for patients to be able to communicate their symptoms and concerns and to participate fully in the decision making process of care (OMH, 2001). For the participants in this study, the fulfillment of this right depended greatly on how well the hospital, through its practices, policies and staff met the physical, emotional, language and cultural needs of the patient. Study participants described the hospital as a place to receive care from competent healthcare providers during a time of need and vulnerability. They also believed that healthcare should be delivered in a safe, respectful and caring manner to those who need it regardless of their station in life. It is through the perceived fulfillment of that right that participants based their experience.

Hospital Practice and CLAS Standards

Lack of language access for healthcare is a denial of healthcare access. Failure to provide language services can be considered a form of discrimination and a violation of the Civil Rights Act of 1964, Title VI. Title VI requires all facilities receiving federal monies to ensure access to those who lack or have limited English language proficiency (USDHHS, 2012).
Consistent with findings in the literature, the participants in this study were not informed of their rights to free access to language services in written or verbal form and frequently experienced inconsistent access to professional interpreters (Andrulis, 2003; Blendon et al, 2007; Cooper & Rowe, 2004; Harari, Davis & Heisler, 2008; IOM, 2002; Tschurtz, Koss, Kupka & Williams, 2011). The study participants had been hospitalized in five different hospitals in Maryland and the District of Columbia (DC) in areas where clustered populations of Hispanics reside. The hospitals ranged in size from small community-based hospitals to large academic medical centers. It is important to note that DC offers reimbursement to agencies for expenses related to language services (Youdelman, 2010). However, only two of the three hospitals located in DC were mentioned by the participants for their consistent and frequent use of interpreter services and quality care. The third hospital in DC was noted to have provided inconsistent language services and inconsistent quality care.

The other two hospitals in which participants were patients were located in the state of Maryland. The language services provided in these hospitals were described by the participants as available but utilized inconsistently. The state of Maryland currently does not offer reimbursement to hospitals and clinics for language services (Youdelman, 2010), thus leaving the individual hospitals and clinics with the responsibility to pay for language services.

The lack of written health-related materials in Spanish is also consistent with the literature (Karliner, et al., 2012; Quan, 2010; Regenstein & Andres, 2014). Quan (2010) found in a review of medical malpractice claims that patients across the U.S. did not receive written materials in their language of choice. Regenstein and Andres (2014) examined the process of translating written patient documents and materials of 35 safety-net hospitals which range from academic medical centers to public hospitals. Safety-net is the term used to describe care that is provided to patients regardless of their ability to pay (Summers, 2011).
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What was found was that hospitals primarily focused their budgets on providing interpreter services and not the translation of written documents. Although the federal mandates require translation of vital documents, it is at the discretion of the provider to decide what is considered a vital document. The lack of budget towards these services can result in delayed, inadequate or denied access to care to those that they are trying to serve. Language services can be costly (Jacobs, Leos, Rathouz & Fu 2011; Jacobs, Shepard, Suaya & Stone, 2004) and federal or state funding to pay for these services may bolster interpreter use (Jacobs et al, 2011; Youdelman, 2010).

Safe and Secure

When participants received language services and forms in Spanish, they had autonomy and felt supported within the organization, which contributed to a positive experience. But what was surprising is what occurred when language support was absent or inconsistent and the participants were limited in their discourse and ability to fully participate in care.

Similar to findings in Garrett et al. (2008) and Hadziabic, Heikkilä, Albin, and Hjelm (2009), some of the study participants considered interpreters necessary to ensure safety, as they prevented errors in care and allowed the participants to better understand their medications and treatments. The need to feel safe and secure as a patient is a universal concept (Mollon, 2014) and is noted in qualitative studies on patient safety by Imberg, (2008) and Rathert, Brandt and Williams (2011). Imberg noted in a qualitative study of Mexican Immigrant women’s childbirth experience that the need to feel safe may be related to their past hospital and personal experiences. Similarly, study participants may be more keenly aware of potential safety errors due to their increased vulnerability from language limitations and past hospital experiences in their country of origin, where the conditions were deplorable.
“Get By” Communication

One significant finding from this study is the practice of “get by” communication. “Get by” communication is a common phrase that refers to the practice of healthcare providers utilizing inadequate language skills to speak with their patients (Diamond, Schenker, Curry, Bradley & Fernandez, 2008). Participants described the practice of speaking “get by” limited Spanish and or limited English during encounters with healthcare providers. Although this practice is recognized by healthcare providers as providing suboptimal care, the practice continues even when interpreters are available on-site (Diamond et al., 2008; Gurman & Moran, 2008; Kale & Syed, 2010; Thom, 2008).

As stated by the participants in this present study, physicians most often made the decision to utilize interpreters when they considered a need to have critical conversations about care or to provide education. There are studies congruent with this finding (Diamond et al, 2008; Tang, Kruger, Quan & Fernandez, 2014). Also noted by study participants was that interpreter use was higher during physician encounters than nurse encounters. This finding was supported in the literature (Kale & Syed, 2010; Schenker, Pérez-Stable, Nickleach, & Karlner, 2011; Thom. 2008). However, there were no studies found that specifically explored when and how nurses decided to use interpreters to engage with patients. In this study, the majority of the participants reported that nurses used interpreters upon the participants’ request or to educate about a procedure or during admission or discharge. It is plausible that workflow patterns for nurses influence their decision to utilize interpreters. For example, the nurses interact with patients many times over the course of the shift. Each interaction can range from a brief encounter to much longer; whereas a physician may interact with patient once or twice. Other considerations found in the literature as to why healthcare providers fail to use interpreters include lack of education in understanding
how to work with interpreters or the legal implications of not utilizing interpreters (Gurman & Moran, 2008; Kale & Syed, 2010; Phillips, Lie, Encinas, Ahearn & Tiso, 2011).

Consistent with several studies, study participants appreciated the effort put forth by providers to speak “get by” or “un poquito” Spanish. But consistent with other studies conducted with patients with language limitations, bilingual providers or interpreters were preferred (Brooks et al., 2000; Garcia & Duckett, 2009; Garrett et al., 2008; Hadziabdic, Heikkilä, Albin, & Hjelm, 2009; Jones, 2012; Simon et al., 2013).

Several reasons were noted by the study participants for the preference for interpreters. All the study participants spoke of their preference to speak and read in Spanish regardless of their ability to speak or read in English. Participants who had limited English proficiency reported that illness and lack of energy made it more difficult to speak English. This is consistent with two qualitative studies of the experiences hospitalized patients with language barriers conducted outside of the U.S. (Eckhardt, Mott & Andrew, 2006; Roberts, 1994). These findings also support previous research regarding those with language barriers who may find it difficult to effectively communicate when under stress (Coffman & Norton, 2010; Kim, 2000; Ulrey & Amason, 2001) and being hospitalized may further compound existing underlying stress. Ding and Hargraves (2010) found that immigrants with language barriers were more likely to report anxiety and stress. This is important to note as it would make it difficult for the patient to speak “get by” English and to express understanding.

Self-Advocacy

The findings related to self-advocacy were complex and varied among participants. There are several possible explanations for the differences in self-advocacy among the participants. Explanations may include past experiences with the U.S. health system, familiarity with policies and standards of care, individual personality, perceived violation of
human rights, level of dissatisfaction of care, feelings of intimidation, and life-threatening conditions (Derose, 2000; Kaplan et al. 2006; Brashers, Haas & Neidig, 1999; Wiltshire, Cronin, Sarto & Brown, 2006; Jones, 2012). Some participants did not ask for interpreters despite their past utilization in the same institution or other healthcare settings. When the participants were dissatisfied with the care they received, some of them were vocal about their concerns to nursing supervisors and others remained silent. A noted commonality among all those who voiced concerns with their health care was their varied and frequent encounters with the U.S. healthcare system. These participants either had frequent or prolonged hospitalizations or had lived in other parts of the U.S. As a result they were able to make comparisons within and across different healthcare settings. Similarly noted in the literature, when patients in a primary care setting accessed health information prior to a visit they were more likely to participate in decision making and offer suggestions for their own care when meeting with the healthcare provider (Brashers, Haas & Neidig, 1999; Wiltshire, Cronin, Sarto & Brown, 2006). For study participants, awareness of hospital policies, standards of practice and language services, allowed them to better advocate for themselves. Also, as seen with these participants, chronic illness or threat to life can prompt patients to advocate for themselves (Brashers, Haas & Neidig, 1999; Wiltshire, Cronin, Sarto & Brown, 2006). Participants also advocated for themselves when they perceived their basic human rights or rights as insured healthcare consumers were violated. This finding was supported in Derose (2000) and Kaplan et al. (2006). The personality of the patient also deserves consideration, as more vocal or assertive people are more likely to advocate for themselves (Kaplan et al., 2006; Wiltshire et al. 2006). Lastly, as hospitals continue to focus on patient satisfaction as a quality indicator of care; patient satisfaction surveys are administered in the patients’ primary language, as was the case with one participant, creating a culture of empowerment and inclusivity for the NEP and LEP patient.
On the other hand, several explanations may provide insight as to why participants did not advocate for themselves. Kaplan et al. (2006) found that participants resigned themselves to discrimination and inequalities of care and speaking up would be pointless. Embarrassment due to language limitations may also prevent patients from speaking up (Derose, 2000; Harari, Davis & Heisler, 2008; Kaplan et al, 2006). Their hesitancy to ask may be related to not wanting to appear bothersome, or feeling intimidated (Jones, 2012). Understanding all of these factors is particularly important as some patients may be aware of their rights or a particular service and may not advocate for themselves. Therefore, the nurse should assume responsibility to assess the language needs of a patient, initiate services as appropriate and encourage and create a culture of advocacy.

**Family Support**

Where and when the participants did not advocate for themselves, the family was often present and intervened on their behalf. As participants experienced disruption to their lives, family members provided emotional and physical support and served as a safety-net (Campbell-Grossman, Hudson, Keating-Lefler, Yank & Obafunwa, 2009; Derose, 2000; Eckhardt et al., 2006; Hicks et al., 2008; Imberg, 2008; Roberts, 1994). Participants in the present study noted that family members and friends assisted with healthcare access and nursing care issues. When interpreters or bilingual providers were unavailable, family and friends filled this role. This practice has legal and ethical implications and can be a violation of HIPAA and CLAS standards (OMH, 2013, pg.1; Office of Civil Rights [OCR], para. 1, 2014).

The CLAS standard calls for healthcare providers to “Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individual and/or minors as interpreters should be avoided” (OMH, 2013, pg.1). In this study,
participants valued family support and relied on family for interpretation and felt family members assisted them in their understanding of medical treatment. However, other studies suggested mixed results regarding patients’ feelings on the use of family members for interpretation. In some cultures where decisions are made as a family, patients may feel safer discussing embarrassing subject matters with family members over interpreters as noted in the Kuo and Fagan (1999) study. Conversely, other studies suggested that patients feel use of family members as interpreters to be intrusive (Ngo-Metzger et al., 2003) or inappropriate for male and female discussion of sensitive information (Gerrish, 2001). Using family members as interpreters may have a negative impact on the patient-provider relationship (Lee, Batal, Maselli, & Kutner, 2002). Another issue with using family members involves the use of minor children to interpret. Using minor children places the patient at risk for potential errors and psychological harm to children who may not have the interpreting skills or psychological development to interpret (Flores, Abreu, Barone, Bachur & Lin, 2012).

Although it may be legally acceptable for family members and friends to act as interpreters if the patient consents, there are ethical considerations (Betancourt, Renfrew, Green, Lopez & Wasserman, 2012). Patients have the right to refuse an interpreter, but how well-informed a patient is in understanding the risks of refusal is unclear in the literature and deserves further examination (Donnelly, 2000). When patients agree or prefer to have a family member provide interpretation, autonomy can be compromised as the family member may not provide full disclosure of information because it is considered harmful or taboo to the patient (Barnes, Davis, Moran, Portillo & Koenig, 1998). Further, the right to privacy and confidentiality is potentially violated (Donnelly, 2000; Barnes et al., 1998).

The patient-interpreter connection
Interpreters were viewed by study participants as a source of support, especially when family members were not present or were unable to provide interpretation. While not always possible, establishing a relationship with the interpreter in order to develop trust was also noted, as was similarly reported by Imberg (2008). The participants in the present study who utilized interpreters with consistency and frequency considered them helpful and an important aspect of their care and viewed them as members of the healthcare team. Preloran, Browner and Lieber (2005) found that an interpreter’s communication style may actually influence patients’ decision making. This could lead to ethical dilemmas as patients may feel coerced to make a decision based on the interpreter’s interaction. This further speaks for the need to use professionally certified interpreters who follow a code of ethics and practice standards and maintain professional boundaries (International Medical Interpreters Association [IMIA], 2010; National Council on Interpreting in Health Care [NCHIC], 2005).

The perceived gains from utilizing interpreters may explain why distrust toward interpreters (Brooks et al., 2000; Cioffi, 2003; Hadziabic, Heikkilä, Albin, & Hjelm, 2009; Frey et al., 2013) and feeling of resentment because of dependence on interpreters (Hadziabic, Heikkilä, Albin, & Hjelm, 2009) were not evident in this present study. One consideration is whether the participants would have distrust or feelings of embarrassment if the information being relayed was considered too personal to divulge to an interpreter (Frey et al., 2013).

It should be noted that the study participants may have become accustomed to the use of interpreters because the clinic in which many of the participants received their healthcare utilized interpreters. The ease with which the participants communicated during the interviews was evident as they were purposeful in directing their eye contact and facial expressions toward both the researcher and interpreter.
The patient-physician encounter

Other pertinent findings from this study emerged from the participants’ observations about the care and encounters with nurses and physicians. The participants’ observations about physicians were all positive, while there were mixed perceptions about the nurses. This may be explained by the participants differing expectations of the physicians and nurses during an encounter.

The interpersonal skills of the nurses and physicians were important to the participants in this study. The value placed on the interpersonal skills may be related to the Hispanic cultural concept of “personalismo”, which is a friendly manner that is demonstrated through active listening, and a gentle touch may be viewed as an attempt to relate with a person and build rapport (Jones, 2012; Warda, 2000).

Interestingly, as noted above, none of the participants had negative perceptions of their encounters with the physicians. When they spoke of physicians, it was largely about their clinical acumen. Several participants spoke highly of physicians who approached the participant as a partner in care and included them in decision making. Approaching the patient as a partner in care has been identified as a predictor for patient satisfaction for hospitalized Hispanics (Hicks et al., 2008). However, Schenker et al. (2010) found that LEP patients when compared to EP patients were less likely to report that the physician included them in care. Schenker et al. (2010) did not directly examine the encounters or query subjects about the presence of interpreters during the encounter. However, many of the participants in the present study reported physicians utilizing interpreters and in some cases bilingual nurses, during encounters with patients which would allow them to participate in discussions about their care. This may explain in part participants’ positive perceptions of the encounters. Another explanation is that physicians may have used non-verbal skills such
as tone of voice and eye contact to convey concern to patients (Ngo-Metzger, Sorkin & Phillips, 2009).

**The patient-nurse encounter**

Of all the factors contributing to the patient experience, the patient-nurse relationship appeared to have the greatest impact on the overall experience of participants in this study, which was also noted by Imberg (2008). The perceptions were that of the nurse as a caregiver and as an employee of the hospital. In the role of caregiver, participants expected nurses to be caring, meet their needs and to provide and maintain a safe environment. When the nurse met the expectation the participants developed trust or “confianza” in the nurse. Confianza is a cultural concept of trust or confidence in another individual (Dayer-Berenson, 2014).

Nurses who paid attention and anticipated and met the needs of the participants, resulted in the participants feeling secure, valued and cared for resulting in trust and feeling connected to the nurse. Consistent with other studies, the participants perceived that nurses who attempted to speak to the them through an interpreter or used “un poquito” “a little” Spanish to provide comfort and connectedness were perceived as empathetic (Cioffi, 2003; Narayanasamy, 2003; Preloran, Browner, & Lieber, 2005; Roberts, 1994). The findings of this study are consistent with those reported in the grounded theory study of Jones (2012) that explored the concept of “confianza” in hospitalized Mexican Americans. Jones found that trust building between the patient and nurse is cyclical in nature and based on the patient having a need and the nurse being available to try to meet the needs and provide comfort to the patient. The nurse being present and meeting the needs of the patient leads to trust and subsequently to patients confiding in the nurse if needed. Furthermore, as seen in this study, if needs are not met, the relationship is halted and trust is lost. The participants in this study
who lost trust in the nurse experienced a perceived lack of respect, anxiety, emotional stress, anger and powerlessness.

This is an important finding as the participants perceived the nursing care or attention to their physical needs beyond the physical act of care or relief of symptoms, but rather a representation of a nurse’s concern for them as human beings (“somos humanos”) and a show of respect. The expressed or demonstrated concern by the nurse is particularly important for this patient population who may experience discrimination and marginalization in their daily lives because of language or ethnicity (D’Anna, Ponce & Siegel, 2010; Harari, Davis & Heisler, 2008; Keller et al., 2010; Schenker et al., 2010; Torres & Wallace, 2013).

An unexpected finding was that many participants in this study felt that there was no difference between the frequencies of conversation with bilingual and English speaking nurses. As supported in the literature, study participants described conversations as mostly limited to asking questions related to physical assessment, care or the task being performed rather than “small talk” (Chan, Jones, Fung & Wu, 2011). Again, similar to the findings of Imberg (2008), most participants were satisfied with these focused conversations as they were more concerned with the care they received.

A possible explanation for this focused conversation was noted in a focus group study conducted by Chan et al. (2011), in which hospital-based nurses were more engaged in conversation with patients when communication had purpose, such as collecting information, teaching about a procedure during an assessment or administering medication. Further, nurses cited perceived time constraints that prevented them from taking time to get to know the patient. The art of “small talk” is of particular importance, because it is often during this time when the nurse connects with the patient and learns more about the patient allowing the nurse to provide more holistic care (Chan et al., 2011; Zani, Marcon, Tonete & Garcia de
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Lima Parada, 2014). While there may be the absence of “small talk” between patients and nurses regardless of language concordance, LEP and NEP patients are at greater risk of not receiving holistic care, more likely to have more needs, and less likely to have their needs addressed (Karliner et al., 2012; Schenker, 2010).

Participants viewed personnel issues as a barrier to a therapeutic patient-nurse relationship. Inadequate staffing and perceived low level of job satisfaction of nurses were perceived by the participants as also resulting in poor communication, uncaring behavior by the nurses and poor responsiveness to needs, leaving the participants to feel unsafe and insecure. This is an added stressor as the patient begins to worry about the needs of the nurse. Likewise, Teng, Hsiao and Chao’s (2010) findings suggested that increased stress experienced by nurses affected their ability to be empathetic and responsive to patients. Also, the nurse may have perceived that the participant created an added stress and this may have contributed to dissatisfaction. Bernard (2006) found that nurses reported increased stress when providing care to NEP or LEP patients. Nurses were found to be most concerned about adequately treating pain and communicating effectively (Bernard, 2006; Jones, 2008; Pytel, 2009).

Several participants perceived that the nursing care on nightshift was of lower quality when compared to dayshift. This perception may be due to the decreased availability of services on nightshift as participants talked about decreased access to services and to nursing staff. Another possible explanation is that the participants and nurses have differing perspectives of what is considered a caring behavior (Papastavrou, Efstathiou & Charalambous, 2011) or what nursing care behaviors are considered important (Suliman, Welmann, Omer & Thomas, 2009). One such example is that study participants wanted the nurses on nightshift to come and check on them instead of the common practice of patients being told to “push the call light” if they need something. Consistent with a study by Jones
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(2012), several of the participants perceived this practice as a negative behavior of the nurse as an indication that they did not want to be “bothered” with them.

**The Discharge Instructions**

Some participants indicated that they understood their care and discharge instructions, while other participants experienced misunderstanding of care and discharge instructions, which resulted in negative emotions, physical and financial loss. Several strategies discussed in the literature may have contributed to the participants’ understanding of their discharge instructions. One possible explanation is the timing of participants’ utilization of interpreters and this may have made a difference in their ability to understand instructions provided at hospital discharge. The literature supported the use of interpreters by physicians at specific times, such as admission, labor and delivery, and at discharge from the hospital. When professional interpreters were utilized during admission, discharge or both, outcomes improved (Lindholm, Hargraves, Ferguson & Reed, 2012). These points are critical transition periods at which pertinent information is exchanged and the presence of interpreters may prevent possible mistakes (Betancourt et al., 2012; Jack et al., 2013; Karliner et al., 2012; National Quality Forum [NQF], 2014). However, these time points may not be sufficient for patient understanding. Patient education is ongoing throughout the hospitalization. NEP and LEP patients are at risk for not receiving adequate education if interpreters are not used throughout their stay (Hicks, 2008; Jennings, 2013).

Another possible explanation for why some participants understood their discharge instructions is to understand the interaction of the patient and nurse during discharge instructions. Karliner et al. (2012) examined patients’ understanding of discharge instructions and medications after their attendance at a nurse-run discharge counseling session. Comparable rates of understanding of medications and discharge instructions
between EP patients and NEP or LEP patients who did not have a hospital-provided interpreter or family member present were found. The actual exchanges between the nurse and patient were not observed by the researcher, but this finding suggested that there are strategies used by the nurse to assist the patient in understanding (Karliner et al., 2012). Two strategies mentioned by study participants were the nurses’ utilization of simple phrases and gestures that helped with understanding. Similarly, Simon et al. (2013) found that English speakers reported difficulty understanding “medical jargon”, which was not found with Spanish speakers who utilized interpreters. The authors hypothesized that the interpreters may have used simpler language that enhanced understanding.

Another possible explanation was found in this study. Four study participants reported that the health education they received in the community prior to hospitalization prepared them for understanding discharge instructions in the hospital. The literature on preoperative education does not specifically address the cultural and language needs of this population. However, receiving education prior to hospitalization can be an effective method for improving outcomes for various surgical procedures, reducing anxiety (Inman, Jacobson, Maxson, Wang & Lohse, 2013; Sadati et al., 2013) and decreasing post-operative complications in surgical patients (Sadati et al., 2013).

Overall, family members and friends serving as interpreters during discharge has been associated with decreased understanding or misunderstandings for the patient (Karliner et al., 2012). But in this present study, participants perceived family and friends as valuable in assisting them in gaining increased understanding. In trying to account for this discrepancy, it would be necessary to explore the health literacy and language literacy of the family members and friends. Participants stated that family members and friends had better language skills, health literacy or both compared to the participants’ own health literacy and language literacy. Based on the participants’ descriptions, there is a wide range of language
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skills among family members, ranging from knowing a few words in English to full fluency. This variation may account for the reason some patients may have full understanding while others continue to have misunderstanding about their care (Bentacourt, Renfrew, Green, Lopez & Wasserman, 2012). Several participants in this present study may have had full understanding of their discharge instructions because the reason for their hospitalization and the care was not complex (Karliner et al, 2012). Also, as in the case of those admitted for childbirth or who had previous hospitalizations for the same illness or condition, participants understood what to expect (Karliner et al, 2012).

**Transitioning to home**

Participants who had difficulty understanding part or all of their treatments or discharge instructions experienced some interplay of language discordance, health illiteracy and language illiteracy and this was particularly evident as they described their hospital discharge. This interplay is similar to what Schyve (2007) described as a “triple threat’, in which health literacy, cultural and language differences prevent the patient from engaging in effective communication. This study examined participants’ perception of the process of hospital discharge, providing some insight to what they experienced. Evidence in the literature indicates that NEP and LEP patients receive standard care but discharge instructions at lower rates (Chandra, Clark, & Camargo, 2009) and are at greater risk for experiencing medication errors and missed appointments and readmission than English proficient (EP) patients (Ash & Brandt, 2006; Karliner et al., 2012; Lindholm, et al., 2012). The study participants reported receiving discharge instructions, but often without a professional interpreter, bilingual healthcare provider or materials in Spanish. For some participants, the lack of language support resulted in misunderstandings of treatment and diagnosis. This finding is significant as it offers a possible explanation as to how medication errors and
readmission rates could occur.

Limitations

There are several limitations of this study. First, the researcher was not Spanish speaking which necessitated the use of interpreters. Therefore, there was always the possibility that some misinterpretation could have occurred (Esposito, 2001). Second, the interview process was slowed by the flow of the interpretation process, which may have interfered with the ability to obtain rich descriptions of the experience from the participants. Third, while attempts were made to recruit a diverse sample through theoretical sampling, the majority of the participants were females who were hospitalized for childbirth. Also, the participants were older, as apparently younger women (18-24) declined to participate. The younger women who declined were often accompanied by their partner who made the decision for the women to participate or not. Inclusion of a younger sample could have influenced the study’s findings. Fourth, participants may have chosen not to participate due to concerns about deportation and those who participated may not have provided honest responses because of the same concern. Fifth, there is a limitation in the validity of the study. At the end of the interviews, all the participants were asked if they would like to be contacted at the end of the study for a review of the study to “review their story”. Seven of the participants, declined as they were satisfied with the interview. Four participants agreed to participate in a member check. However, participants were contacted by mail twice and only one of the participants met with the research and interpreter to participate in the member check. The participant did agree with the transcript and the overall findings of the study. Finally, the study participants were recruited from a limited geographic area and from five hospitals, which may affect the transferability of findings to other populations.
Implications for practice

Despite federal and state laws, and in some cases funding reimbursement for interpreters, interpreters are still underutilized. To improve the hospital experience of the NEP or LEP patient, language discordance between a patient and provider must be considered an important patient safety issue (Jack et al., 2013; Standiford, Nolan, Harris & Bernstein, 2009). Nurses require education about the legal and ethical standards related to provision of interpretation. Further, in their role as patient advocates, nurses need to educate patients about their right to free access to language services in written or verbal form (Parés-Avila, Sobralske & Katz 2011). In order to bring this issue front and center, hospital administrators can implement hospital policies, interventions and include LEP patient safety quality indicators for monitoring within their facilities (Huang, Ramos, Jones, & Regenstein, 2009; Jack et al., 2013; Standiford et al., 2009). Visual cues, such as colored wrist bands for the patient to wear or highlighted colors in the electronic health record, could be used as a patient alert system to remind the nurses to use interpreters.

To increase the utilization of interpreters during patient-nurse encounters different language service modalities must be made available to meet the workflow needs (Locatis et al., 2009; Schenker et al., 2011). This study highlighted the difficulties patients can experience when language literacy and health literacy limitations are present. Practical interventions can be implemented to address these issues. A simple screening using four questions can be included in the nursing assessment to accurately assess for issues of language fluency and health literacy questions on the admission assessment: 1) “What language do you prefer to talk with your nurse or doctor?” (Standiford et al., 2009, pg. 1696). 2) “How often do you have problems learning about your medical condition because of difficulty understanding written information?” 3) “How confident are you filling out medical...
forms by yourself?” and 4) “How often do you have someone help you read hospital materials?” (Chew, Bradley & Boyko, 2004, pg. 591)

Using interpreters during critical conversations and designated points of the hospitalization, in particular admission and discharge, may improve health outcomes and patient well-being (Lindholm et al., 2012), but it does not address the necessary therapeutic relationship between the patient and nurse. As was found in this study, communication between the patient and nurse is an essential component of the hospital experience for the patient.

In working with NEP and LEP Hispanic patients, nurses need to be aware of the care behaviors that are important to this population. For example, taking the time for “small talk” and demonstrating empathy and trying to connect by speaking some Spanish during patient encounters. Hedges, Nichols and Filoteo (2012) found improvements in patient satisfaction, in particular, Spanish-speaking patients when “Focus Time” was implemented. This intervention was an uninterrupted time between the patient and or family and the nurse to maintain the therapeutic relationship, and for Spanish-speaking patients an interpreter was provided.

Finally, as the patient transitions to home, following specific interventions such as those outlined in the “Re-Engineered Discharge Toolkit” (Jack et al., 2013) and a specific nurse-run discharge counseling session could be implemented (Karliner et al., 2012). The interventions outlined in these initiatives are aimed at addressing the health literacy and language assistance, and can provide additional support to the NEP and LEP patient. It is particularly important for patients to have materials written in their language (DeWalt et al., 2010; OMH, 2013).
Implications for education

Although increasing the numbers of health care providers who are bilingual or are members from underrepresented cultural groups in the health care workforce is important, all health care providers need educational experiences that allow for knowledge attainment and practical application of cultural or transcultural concepts (Campinha-Bacote, 2002; Institute of Medicine [IOM], 2002; Singleton & Krause, 2009).

Standardized patients (SP) have been an effective educational tool in teaching therapeutic communication in both medicine and nursing and it seems a natural progression to use this approach or strategy to teach intercultural communication. Inclusion of SPs is a useful teaching strategy that allows students to learn important communication skills without causing cultural pain (Jeffreys, 2006). Limited financial and human resources (Vessey & Huss, 2002) and lack of faculty confidence and ability to implement cultural competence programs (Boyle, 2007; Jeffreys, 2006; Roberts, Warda, Garbutt & Curry, 2014) are possible barriers to successful use this teaching strategy.

Essential to successful communication on any level is the issue of empathy. Cultural empathy, as described by Zhu (2011), involves internal feeling with an exchange of external emoting by both parties. In this exchange, it is important for the nurse to validate the perceived feelings of the patient. Many have debated whether empathy can be taught or truly expressed in a simulated experience. It is argued that any empathy observed with SPs is superficial (Wear & Varley, 2008). Counter to this argument is the view that a level of empathy can be achieved during these encounters (Kyeongra, Woomer, Agbemenu, & Williams, 2014; Teherani, Hauer, & O'Sullivan, 2008). Using SPs can be an effective tool for teaching intercultural communication, but it must be done in a carefully constructed...
manner that does not contribute to the perpetuation of stereotypes (Shearer & Davidhizar, 2003).

Development of simulations with language discordant patient scenarios with a focus on patient safety can be an effective method to teach the importance of utilization of interpreters. Also, simulations can be used to teach students effective strategies on how to work with interpreters.

Implications for research

The study participants indicated that language differences made it challenging to engage with nurses. This is important as nurses need to build rapport, advocate and provide education for patients. The hospital setting requires nurses to effectively communicate with patients and families to gather health information during stressful or rapidly changing situations. There is limited research conducted in the U.S. exploring the impact of language barriers on the patient-nurse relationship in the hospital setting. While the findings from this study were supported in the literature from studies conducted outside of the U.S., the sociocultural differences warrant further exploration.

Nurses do not utilize interpreters to the same extent that physicians do and time constraints and the nature of the workflow may account for those differences. More research is needed to examine the different interpreter modalities and measure for outcomes with those modalities. Furthermore, more research needs to be conducted to evaluate the effectiveness of cultural competence programs (Gonzalez-Espada, Ochoa & Vargas, 2006; Narayanasamy, 2003; Park et al., 2005; RWJF, 2004). Cultural competence education intervention studies aimed at improving use of interpreter services by nurses should be conducted. Also, further exploration of what occurs during the interaction of the nurse and the NEP or LEP patient during the discharge process is warranted. Quality improvement studies should be
undertaken to explore if specific culturally appropriate interventions improve outcomes on nursing quality indicators for NEP and LEP patients and those with health literacy barriers. Ethnographic studies could explore the nurse-patient-interpreter triad. Preloran, Browner and Lieber (2005) found that the interpreters’ approach may actually influence patients’ decision making. Further research is needed to explore the approach of the interpreter during an encounter and its effect on decisions made by patients.

The sample is this study was limited to an older sample of mostly childbearing Hispanic women who were hospitalized in 5 hospitals located in the District of Columbia and Maryland, which limited generalizability. Perceptions of care of the NEP and LEP as a vulnerable population needs continued monitoring (Jack et al., 2013). However, a quantitative tool would be necessary for a larger sample size across multiple hospitals with varied medical diagnoses. The Picker Patient Experience Questionnaire-33 adapted by Barrio-Cantalejo et al., (2009) is a culturally congruent valid and reliable tool to measure patient satisfaction among Hispanic patients. Many of the care items that are measured on this tool are similar to the participant statements and study findings of this study. This tool adds validity to the findings of this study. This tool was adapted from the Picker Patient Experience Questionnaire-15, a 15-item tool written in English (Jenkinson, Coulter & Bruster, 2002).

Further research should be conducted on self-advocacy of patients with language limitations. Community-focused programs should be developed and implemented for NEP and LEP patients to learn to engage in self-advocacy in their encounters with the healthcare system.

Conclusion
This study on the NEP and LEP Hispanic inpatient experience provided important contributions to the current body of literature on language barriers in healthcare. This study is one of the few qualitative studies that have explored the inpatient hospital experience of the NEP or LEP Hispanic participant. Many findings of this study are supported in the current quantitative and qualitative research literature on Hispanics’ healthcare experience. Insight has been provided on what is considered “good”, “bad”, “nice” or “poor” when describing nursing or hospital care.

When hospital policies and standards are not aligned with the CLAS standards, the patients’ right to confidentiality may be violated and access to healthcare may be compromised. Communication challenges had a negative impact on participants’ ability to engage in care and on their sense of autonomy. There were varied methods of communication utilized and despite the federal mandates and realization that the practice is suboptimal, family members are still used as interpreters. Speaking “get by” Spanish and English continues as well. Participants considered interpreters to be important members of the healthcare team who were also seen a source of support. But, not all the participants asked for interpreter services.

A finding from this present study that is consistent with the findings in the literature is that when patients feel supported and respected by physicians and nurses, and by the hospital organization, a sense of well-being is achieved. Participants felt supported by physicians when they were included in the decisions about their care. Participants felt supported by nurses when nurses were empathetic, listened to concerns, anticipated their needs and exhibited caring behaviors. Also, speaking a little Spanish was seen as empathetic and appreciated.
Conversely, a lack of support or lack of respect resulted in the patients’ loss of trust in the nurse and subsequently patients felt unsafe and emotional pain occurred. When patients did not advocate for themselves, then family members provided support.

What has been added to the literature is what occurs during the delivery of discharge instructions and the strategies used by nurses to connect with the patient when there is language discordance. Another finding not previously explored in the literature is the impact of staffing and nursing job satisfaction on the NEP or LEP patient experience which leads to increased feelings of insecurity. The implications of practice, research and education were addressed. The study demonstrates the important role for nurses to advocate for this population and provide safe and effective care.
Appendix IA

Consent Form

Lived experience of Spanish-speaking participants who have been in the hospital

Jana Goodwin MSN, RN - PhD student Villanova University

What is this study about?

This is a research study that seeks to understand the experiences of Hispanic persons who cannot speak English or cannot speak English well, during a hospital stay in the United States in the last six months. In a face-to-face interview you will be asked to talk about your experiences in a U.S. hospital. We will ask you questions about why you were in the hospital and the care you received. You can also share anything that you would like to tell us about your hospital stay. We will not ask questions about your citizenship. A Spanish speaking interpreter will be available during the interview. The interview is expected to last 2 to 3 hours and will be audio-taped. After completion of the study, you may be contacted to share study results with you.

What are the benefits?

This study will not provide any direct benefit to you, but your thoughts will help to further our understanding of the hospital experience for the non-English or limited English speaking Hispanic person. You have the right to have any questions answered before, during, or after the study. Being part of this study is completely voluntary and your decision not to be part of the study or to stop being in the study at any time will involve no penalty or loss of benefits to you, including health care. You may also skip questions if they make you uncomfortable. You will receive a $20 U.S. dollar gift card as consideration for travel and inconvenience at the end of the interview.

What are the risks?

There are no expected physical risks involved in your participation. There is a risk that you might experience distress when recalling a painful memory. If you are in need of immediate counseling services you will be referred to Montgomery County Crisis Center or to your usual source of care. You will be held responsible for all fees. The researcher will stay with you until are connected to services.

Is this confidential?
All information collected in this study will be kept entirely confidential. Your name will not be shown and your being in the study will be kept confidential. All information shared about you or the hospital experience will be kept in a locked filing cabinet available only to the researcher and her advisers. The researcher plans to use the results of this study for publications and presentations. Some of your words may be used in publications and presentations, but your identity will not be shared.

If you have any questions about this study, you can contact the researcher, Jana Goodwin, at Villanova University. If you have any questions about your rights as a research subject in this study, you may contact Dr. Suzanne Smeltzer, Chair of the Villanova University Institutional Review Board at or .

If you agree to take part in this study, please sign below. A copy of the consent form will be given to you with the contact information of the researcher.

Name ________________________
Signature______________________
Date ________________

Name of person obtaining consent_______________
Date_________________
Lived Experience NEP LEP Hospitalized Patient

Appendix IB

Office of Doctoral Student Research

Formulario de Consentimiento Informado

Experiencia vivida por los participantes de habla española que han estado hospitalizados

Jana Goodwin MSN, RN – Estudiante de doctorado de la Universidad de Villanova

¿De que se trata este estudio?

Este es un estudio de investigación que busca comprender las experiencias de los hispanos que no hablan Inglés o no pueden hablar bien el Inglés, durante una estadía en el hospital en los Estados Unidos y en los últimos seis meses. En una entrevista cara a cara, se le pedirá que hable acerca de sus experiencias como paciente en un hospital de Estados Unidos. Vamos a hacer preguntas acerca del por qué estuvo en el hospital y de la atención que recibió. Si usted lo desea, también puede compartir cualquier otra cosa relacionada con su estadía en el hospital. No vamos a hacer preguntas acerca de su estatus migratorio. Un intérprete que habla español estará disponible durante la entrevista. Se espera que la entrevista dure 2 o 3 horas y será grabada en audio. Después de finalizado el estudio, el encuestador puede ponerse en contacto con usted para compartir los resultados.

¿Cuáles son los riesgos?

No existen riesgos físicos involucrados con su participación. Existe la posibilidad de que usted pueda sentirse alterado/alterada al recordar un momento doloroso. Si usted tiene la necesidad de servicios de asesoramiento o consejería se le referirá inmediatamente al Centro de Crisis del Condado de Montgomery (Montgomery County Crisis Center) o a su fuente habitual de atención. Usted será responsable de todos los gastos. El investigador se quedará con usted hasta que sea puesto en contacto con los servicios apropiados.

¿Cuáles son los beneficios?

Este estudio no proporcionará ningún beneficio directo para usted, pero sus ideas ayudarán a mejorar nuestra comprensión acerca de las experiencias de los hispanos que no hablan Inglés o hablan poco Inglés cuando son hospitalizados. Usted tiene el derecho de recibir respuesta a cualquier pregunta que tenga antes, durante o después del estudio. Su participación en este estudio es completamente voluntaria y su decisión de no participar o de
retirarse del estudio en cualquier momento no implicará ninguna sanción o pérdida de beneficios para usted, incluyendo su servicio de salud. Usted también puede no responder a preguntas que lo/la hacen sentir incomodo/a. Al finalizar la entrevista usted recibirá una tarjeta de regalo por $20 como muestra de consideración por su tiempo y cualquier inconveniente que esta entrevista le haya causado.

¿Es este estudio confidencial?

Toda la información recogida en este estudio se mantendrá totalmente confidencial. Su nombre no será publicado y su participación será confidencial. Toda la información compartida acerca de usted o de su experiencia hospitalaria se mantendrán en un armario cerrado con llave accesible sólo al investigador y sus asesores. El investigador planea utilizar los resultados de este estudio para publicaciones y presentaciones. Sin embargo, su identidad no será revelada en ningún momento.

¿Preguntas?

Si usted tiene alguna pregunta acerca de este estudio, puede comunicarse con el investigador, Jana Goodwin, en la Universidad de Villanova llamando al Si usted tiene alguna pregunta con respecto a sus derechos como sujeto de investigación en este estudio, puede comunicarse con la Dra. Suzanne Smeltzer, Presidente de la Junta de Revisión Institucional Universidad de Villanova llamando al

Si usted acepta participar en este estudio ahora que ha leído y comprendido este formulario de consentimiento, por favor firme abajo. Usted recibirá una copia del formulario de consentimiento con la información de contacto del investigador.

Nombre ________________________
Firma______________________
Fecha ________________

La persona que obtiene el consentimiento ____________
Appendix IIA

Office of Doctoral Student Research

Volunteers Wanted for Research Study

Lived experience of Spanish-speaking participants who have been hospitalized

This is a research study that seeks to understand the experiences of Hispanic men and women who do not speak English or cannot speak English well, during a hospitalization in the United States in the last six months. In a face-to-face interview, you are asked to talk about your experiences in a U.S. hospital. A Spanish-speaking interpreter will be available during the interview. The interview is expected to last two or three hours and will be audio recorded.

To be part of this research study, you must:

- Be primarily Spanish speaking
- Be 21 years of age or older
- Have been a patient in a hospital for at least 24 hours in the last 6 months
- Have no present history of mental illness or substance abuse
  - Not be currently receiving treatment for a physical or mental illness

Your being part of this study will help improve our understanding of the hospital experience for Hispanics who speak little or no English.

If you agree to be in the study you will receive a $20 U.S. dollar gift card at the completion of the interview in return travel

For information, call [redacted] Jana Goodwin
Office of Doctoral Student Research

Se Busca Voluntarios para un Estudio de Investigación

Experiencia vivida por los participantes de habla hispana que han sido hospitalizados

Este es un estudio de investigación que pretende comprender las experiencias de los hombres y mujeres hispanos que no hablan inglés o no saben hablar bien el idioma inglés, durante una hospitalización en los Estados Unidos en los últimos seis meses. En una entrevista cara a cara, se le pide que hable de sus experiencias en un hospital en EE.UU. Un intérprete de habla hispana estará disponible durante la entrevista. La entrevista tiene una duración prevista de 2 o 3 horas y será audio grabado.

Para ser parte de este estudio de investigación, debe:

- Hablar principalmente español
- Tener 21 años de edad o más
- Haber sido un paciente en un hospital durante al menos 24 horas en los últimos seis meses
- No debería haber una historia presente de la enfermedad mental o abuso de sustancias
- No estar recibiendo tratamiento médico por una enfermedad médica aguda física o mental

Su participación ayudará a mejorar nuestra comprensión de la experiencia del hospital para los hispanos que hablan poco o nada de inglés.

Los participantes recibirán una tarjeta de regalo por $ 20 EE.UU. en la realización de la entrevista como contrapartida.

Para información, llame Jana Goodwin
Appendix IIIA

Recruitment Script

Hello my name is ____________. How are you today? I am a (research assistant) or (Jana Goodwin, a doctoral student from Villanova University). Can I take a few moments of your time to talk to you about research study? We are conducting a study to understand the experience of Hispanics who have recently been in the hospital.

This is a research study that seeks to understand the experiences of hospitalized Hispanic persons who cannot speak English or cannot speak English well. We would like to know more about how you felt during your hospitalization. Learning about your experience will help healthcare workers understand what patients who speak Spanish experience.

In a face-to-face interview we will talk to you about your experiences here in a U.S. hospital. A Spanish speaking interpreter will be available during the interview by the researcher. The interview will take 2 to 3 hours of your time and will be recorded. After completion of the study, you may be contacted to share study results with you.

There are no anticipated physical risks involved in your participation. There is a risk that you might feel uncomfortable when recalling a painful memory about your hospital experience. If you are in need of immediate counseling services you will be referred to Montgomery County Crisis Center or to your usual source of care. You will be held responsible for all fees. The researcher will stay with you until are connected to services.

This study will not provide any direct benefit to you, but your participation will help to further our understanding of the hospital experience for the non-English or limited English speaking Hispanic person. You have the right to have any questions answered before, during, or after the study.

Your participation in this study is completely voluntary and your decision not to participate or to discontinue participation at any time will involve no penalty or loss of benefits to you, including health care. You may also skip questions if they make you uncomfortable. You will receive a $20 U.S. dollar gift card as consideration for travel and inconvenience at the end of the interview.

All information collected in this study will be kept entirely confidential. Your name will never be revealed and your participation will be kept confidential. All information shared about you or the hospital experience will be kept in a locked filing cabinet accessible only to the researcher and her advisers. The researcher plans to use the results of this study for publications and presentations. Some of your words may be used in publications and presentations, but your identity will not be revealed.

If you agree to participate in this study, we can arrange a time for an interview with Jana Goodwin. Before the start of the interview, Ms. Goodwin will review the study with you and answer any questions. You can sign the consent form at that time. A copy of the consent form will be given to you with the contact information of the researcher.
If you have any questions about this study, you can contact the researcher, Jana Goodwin, at Villanova University. If you have any questions about your rights as a research subject in this study, you may contact Dr. Suzanne Smeltzer, Chair of the Villanova University Institutional Review Board.
Hola mi nombre es ___________. ¿Cómo estás hoy? Soy un ayudante de investigación que trabaja con Jana Goodwin, una estudiante de doctorado de la Universidad de Villanova. ¿Puedo tomar un momento de su tiempo para hablar con usted acerca del estudio de investigación?

Este es un estudio de investigación que busca comprender las experiencias de los hispanos hospitalizados que no pueden hablar Inglés o no puede hablar bien Inglés. Nos gustaría saber más acerca de cómo se sintió durante su estancia de hospital. Aprender acerca de su experiencia ayudará a los trabajadores sanitarios a comprender lo que los pacientes que hablan experiencia española.

Un intérprete que habla español estará disponible durante la entrevista. La entrevista se espera que dure 2 o 3 horas y será grabado en audio. Después de la finalización del estudio, el encuestador puede ponerse en contacto para compartir los resultados del estudio con usted.

No existen riesgos físicos involucrados en su participación. Existe la posibilidad de que usted pueda experimentar angustia al recordar un momento doloroso. Si usted está en necesidad de servicios de asesoramiento inmediatamente se le referirá a Montgomery County Crisis Center o a su fuente habitual de atención. Usted será responsable de todos los gastos. El investigador se quedará con usted hasta que se conectan a los servicios.

Este estudio no proporciona ningún beneficio directo para usted, pero su participación ayudará a mejorar nuestra comprensión de la experiencia en el hospital para las personas hispanas que hablen poco o nada de inglés. Usted posee el derecho de tener cualquier pregunta respondida antes, durante o después del estudio. Su participación en este estudio es completamente voluntaria y su decisión de no participar o dejar de participar en cualquier momento no implicará ninguna sanción o pérdida de beneficios a usted, incluyendo el cuidado de la salud. Usted recibirá un dólar de $ 20 EE.UU. tarjeta de regalo como contrapartida de viajes.

Toda la información recogida en este estudio se mantendrá totalmente confidencial. Su nombre nunca será revelado y su participación será confidencial. Toda la información compartida acerca de usted o la experiencia hospitalaria se mantendrán en un armario cerrado con llave accesible sólo para el investigador y sus asesores. El investigador planea utilizar los resultados de este estudio para publicaciones y presentaciones. Sin embargo, su identidad no será revelada en ningún momento.

Si usted acepta participar en este estudio, se puede concertar una cita para una entrevista con Jana Goodwin. Antes del comienzo de la entrevista, la Sra. Goodwin revisará el estudio con usted y contestar cualquier pregunta. Usted puede firmar el formulario de consentimiento en ese momento. Se dará una copia del formulario de consentimiento para que la información de
contacto del investigador. Si usted acepta participar en este estudio, se puede concertar una cita para una entrevista con Jana Goodwin.

Si usted tiene alguna pregunta acerca de este estudio, puede comunicarse con el investigador, Jana Goodwin, a la Universidad de Villanova. Si usted tiene alguna pregunta con respecto a sus derechos como sujeto de investigación en este estudio, puede comunicarse con la Dra. Suzanne Smeltzer, Presidente de la Junta de Revisión Institucional Universidad de Villanova en
Appendix IVA

Demographics

How many times have you been hospitalize in the last 6 months?_______

Male___Female____

Age_____

What’s your country of birth?

How long have you been living in the U.S.?_____

What’s your English level?

Very good____ Good____ _Not that good____

I don’t speak English____

Where did you learn to speak English?_____________________

Do you have Medical Care?

Yes____

No____

What kind of medical care do you have?

Private (please specified name)____________________

Medicaid____________

Medicare___________

Marital Status

Single____ Married___ Unemployed___

Educational Level

None___ Middle school___ High school___ College____

Divorced____

Employment Status

Full time____

Part Time____
Appendix IVB

Demografía

¿Cuántas veces ha estado hospitalizado en los últimos 6 meses? _________
Masculino__________
Mujer __________
¿Cuántos años tienes? _________
¿Cuál es su país de origen? __________
¿Cuántos años hace que vive en los Estados Unidos? _________
¿Qué tan bien habla usted Inglés?
_____ Muy bien
_____ bien
_____ No muy bien
_____ No habla
¿Dónde aprendió a hablar Inglés? __________
¿Tiene seguro de salud?
Sí _________
No __________
¿Qué tipo de seguro de salud tiene?
Privado (especificar nombre)__________
Medicaid________
Medicare ________

¿Cuál es su estado civil?
Soltero________
Casado________
Divorciado______

Estado Laboral?
Tiempo Completo __________
Medio Tiempo ____________
Desempleado ____________

Nivel de educación?
Ninguna_____
Menos de la secundaria ______
Escuela Secundaria __________
Universitaria ________
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Lived Experience NEP LEP Hospitalized Patient


Lived Experience NEP LEP Hospitalized Patient


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doi:10.1177/104973230201200610
Lived Experience NEP LEP Hospitalized Patient


