INFORMATION TO USERS

The most advanced technology has been used to photograph and reproduce this manuscript from the microfilm master. UMI films the original text directly from the copy submitted. Thus, some dissertation copies are in typewriter face, while others may be from a computer printer.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyrighted material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each oversize page is available as one exposure on a standard 35 mm slide or as a 17" × 23" black and white photographic print for an additional charge.

Photographs included in the original manuscript have been reproduced xerographically in this copy. 35 mm slides or 6" × 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
Caring for the silent stranger: Ethical hospital care for non-English speaking patients

Heitman, Elizabeth, Ph.D.

Rice University, 1988

Copyright ©1988 by Heitman, Elizabeth. All rights reserved.
RICE UNIVERSITY

CARING FOR THE SILENT STRANGER:
ETHICAL HOSPITAL CARE FOR
NON-ENGLISH SPEAKING PATIENTS

by

ELIZABETH HEITMAN

A THESIS SUBMITTED
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
DOCTOR OF PHILOSOPHY

APPROVED, THESIS COMMITTEE

[Signatures]

James E. Sellers
David Rice Professor of Ethics, Director

Niels C. Nielsen, Jr.
J. Newton Rayzor Professor of Philosophy and Religious Thought

Linda S. Adair
Associate Professor of Anthropology

Stanley J. Reiser
Adjunct Professor of Religious Studies

Houston, Texas

April, 1988
Copyright

Elizabeth Heitman
1988
Acknowledgments

The research and writing of this dissertation would not have been possible without the the willing help and constant encouragement of the following people, to whom I am indebted:

James M. Berry; Emily Heitman; Kristin Heitman; Silvia Louie; Maria Teresa Leal; Linda S. Adair; Stephen L. Klineberg; Luisa Kluger; Linda W. Winter; Janice L. Glover; Juan Valdez; the patient representative staff of the study hospital; the librarians of the Fondren Library Government Documents Room; and the hundreds of hospital patients who have shared their experiences with me, before, during, and after the study.

This work is dedicated to Paulo, Ligia, and Rodrigo, and the many like them who turn to us for help.
Elizabeth Heitman
Caring for the Silent Stranger: Ethical Hospital Care For Non-English Speaking Patients

Abstract

The past generation's revolution in medical ethics has had a tremendous impact on the definition of the therapeutic relationship. Where the traditional virtuous physician motivated by philanthropy once practiced "therapeutic deception", today health care practitioners in a variety of disciplines are held to a professional standard which demands that the therapeutic relationship be based in good communication between patient and caregiver. Medical ethics now looks to the images of contractual negotiation and covenantal compassionate presence to overcome the clash of values which may occur when patient and caregiver meet as strangers.

In the U.S., a significant number of hospital patients are not only strangers to their caregivers and American medicine, they are strangers to the very language in which differences could be explained and strong therapeutic relationships established. Non-English speaking patients pose a complex problem for the ethical dedication to informed consent, as they are unable to take an active part in treatment without translation. In a study of 226 Hispanic hospital patients, non-English speaking patients were shown to have limited understanding of their conditions
and treatment, and almost no meaningful interaction with their caregivers. Ironically, where patient satisfaction with medical care has been shown repeatedly to be based in factors of communication, non-English speaking patients placed almost no importance on their communication with the staff. Overall they had little interest in the active role that contemporary ethics assigns to patients.

Non-English speaking patients' limited role in their own care also poses legal questions about the validity of their consent to treatment. Few non-English speaking patients are provided with translation, even for official consent documents. There is some indication, moreover, that an inability to speak English contributes to longer hospital stays. Providing the professional medical translation which would afford non-English speaking patients the ethical hospital care that they deserve might not only ensure against litigation, it may also save money for hospitals, insurers, and public health funds.
Contents

Abstract

Acknowledgments

List of Tables

Chapter 1. Introduction - Caring for Strangers: the Role of Communication in the New Model of Health Care

The ethics of covenant, contract, communication, and compassion in the modern therapeutic relationship 7

The stranger in the hospital -- alone in a silent world 56

Chapter 2. Introduction to the Hospital Study

Study design 67

Characteristics of the hospital's Hispanic population 72

Encounters between patients and hospital staff 90

Chapter 3. The Patients' Perspective on Communication with their Caregivers 108

Interview population and methods 109

Interaction with the medical staff 112

Communication and patients' satisfaction with care 120

Chapter 4. Staff Views on Communication with NESPs 181

Interview population and methods 181

Staff reactions to caring for NESPs 185

Comparing staff and patient perceptions as an indication of the quality of their communication 209
Chapter 5. The Ethics, Economics, and Legal Aspects of Translation  235

Communication, consent, and translation for NESPs  236

Communicating with NESPs through translation  264

Economic incentives for providing translation: shorter stays, fewer tests, wealthy foreign patients  283

Chapter 6. Epilogue - Teaching Patients to Speak for Themselves  301

Bibliography  335

Appendices  357
### List of tables

<table>
<thead>
<tr>
<th>Caption</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1. Profile of total Hispanic population</td>
<td>73</td>
</tr>
<tr>
<td>Table 2. Profile of survey sample</td>
<td>75</td>
</tr>
<tr>
<td>Table 3. Residence</td>
<td>78</td>
</tr>
<tr>
<td>Table 4. Citizenship</td>
<td>78</td>
</tr>
<tr>
<td>Table 5. Employment status</td>
<td>79</td>
</tr>
<tr>
<td>Table 6. Educational level</td>
<td>80</td>
</tr>
<tr>
<td>Table 7. Total annual household income - 1984</td>
<td>81</td>
</tr>
<tr>
<td>Table 8. Hospitalized previously</td>
<td>83</td>
</tr>
<tr>
<td>Table 9. Hospitalized previously at study hospital</td>
<td>83</td>
</tr>
<tr>
<td>Table 10. Hospitalized previously with similar condition</td>
<td>84</td>
</tr>
<tr>
<td>Table 11. Time since last admission</td>
<td>84</td>
</tr>
<tr>
<td>Table 12. Time between onset and admission</td>
<td>86</td>
</tr>
<tr>
<td>Table 13. Treatment before hospitalization</td>
<td>87</td>
</tr>
<tr>
<td>Table 14. Reason for going to the hospital</td>
<td>87</td>
</tr>
<tr>
<td>Table 15. Patients reporting visits from staff members</td>
<td>91</td>
</tr>
<tr>
<td>Table 16. Patients who knew staff members' names</td>
<td>93</td>
</tr>
<tr>
<td>Table 17. &quot;How does your primary doctor usually try to communicate with you?&quot;</td>
<td>114</td>
</tr>
<tr>
<td>Table 18. &quot;How well do you usually understand your primary doctor?&quot;</td>
<td>115</td>
</tr>
<tr>
<td>Table 19. &quot;Do you talk to your primary doctor?&quot;</td>
<td>116</td>
</tr>
<tr>
<td>Table 20. &quot;How do you usually try to communicate with your primary doctor?</td>
<td>118</td>
</tr>
<tr>
<td>Table 21. &quot;Do you feel that your primary doctor usually gives you an opportunity to ask questions?&quot;</td>
<td>119</td>
</tr>
</tbody>
</table>
Table 22. "Are you satisfied with the way that your primary doctor usually answers your questions?"

Table 23. "Are you satisfied with the care that he or she gives you?"

Table 24. "Why do you say that you are satisfied?"

Table 25. "How do the residents usually try to communicate with you?"

Table 26. "How well do you usually understand the residents?"

Table 27. "Do you talk to the residents?"

Table 27a. "Why don't you talk to them?"

Table 28. "How do you usually try to communicate with the residents?"

Table 29. "Do you feel that the residents usually give you an opportunity to ask questions?"

Table 30. "Are you satisfied with the way that the residents usually answer your questions?"

Table 31. "Are you satisfied with the care that the residents give you?"

Table 32. "Why do you say that you are satisfied?"

Table 32a. "Why do you say that you are not satisfied?"

Table 33. "What does the doctor say is wrong with you?"

Table 34. "What treatment have you had?"

Table 35. "When do you expect to go home?"

Table 35a. "When do you expect to go home? - adjusted"

Table 36. "Do the nurses talk to you?"
Table 36a. "Why do you think that they don't talk?"

Table 37. "How do the nurses usually try to communicate with you?"

Table 38. "How well do you usually understand your nurses?"

Table 39. "Do you talk to the nurses?"

Table 39a. "Why don't you talk to them?"

Table 40. "How do you usually try to communicate with the nurses?"

Table 41. "Do you feel that the nurses usually give you an opportunity to ask questions?"

Table 42. "Are you satisfied with the way that the nurses usually answer your questions?"

Table 43. "Are you satisfied with the care that the nurses give you?"

Table 44. "Why do you say that you are satisfied?"

Table 45. "Are you satisfied with the hospital in general?"

Table 46. "Do you speak Spanish?"

Table 47. "How do you try to communicate with your NESP(s)?"

Table 48. "Do you feel that you are able to give your best care to patients who don't speak English?"

Table 49. "Why do you say that you can't give your best care to NESP?"

Table 50. "Why do you say that you can give your best care to NESP?"

Table 51. "How would you rate the total care given to NESP?"

Table 52. "Why do you say that NESP get the same care, in general as ESP?"
Table 53. "Why do you say that NESP's get worse care, in general as ESP's?"  
Table 54. "What do you feel is particularly difficult about caring for NESP's?"  
Table 55. "How often does the doctor visit the patient?"  
Table 56. "How much time does the doctor spend with the patient during a visit?"  
Table 57. "How well does the doctor speak Spanish?"  
Table 58. "How well does the doctor understand the patient?"  
Table 59. "How well does the patient understand the doctor?"  
Table 60. "How much opportunity does the patient have for discussion with the doctor?"  
Table 61. "How often does the nurse visit the patient?"  
Table 62. "How much time does the nurse spend with the patient during a visit?"  
Table 63. "How well does the nurse speak Spanish?"  
Table 64. "How well does the nurse understand the patient?"  
Table 65. "How well does the patient understand the nurse?"  
Table 66. "How much opportunity does the patient have for discussion with the nurse?"  
Table 67. Procedures and translation of consent forms  
Table 68. Procedures and translation of consent forms - detailed  
Table 69. Translator role  
Table 70. Rate of translation and translator role by service
Chapter 1

Introduction

Caring for Strangers: the Role of Communication in the New Model of Health Care

Among the many changes that have occurred in health care in the last generation, few have been as revolutionary as the redefinition of the ideal relationship between health care professionals and their patients. The traditional paternalistic model of health care which vests all authority with the professional, especially the physician, has come under increasing criticism in the last two decades from many who would give patients an active role in treatment. This change was prompted initially by two phenomena: society's growing interest in individual rights and liberties, and advances in medical science which raised complex new moral questions to which there was seldom only one right answer. As the discipline of medical ethics has developed in response to these and other factors, it has focused repeatedly on the conclusion that a therapeutic relationship must be able to accommodate the often disparate moral values of health care professionals -- doctors in particular -- and their patients.

Such a relationship, as defined over the past 20 years, requires that the practitioner recognize and respect the patient's moral autonomy, impart vital information about his
or her condition and options for treatment, and share
decision-making authority by listening to the patient's
fears, wishes, and expectations, ensuring that the patient
gives free and informed consent to treatment. Essential to
this new ethical vision of the patient-practitioner
relationship is the conviction that therapeutic interaction
is founded upon and sustained by open communication. As
this new image has developed, research in the social
sciences has supported ethicists' conclusions about the
value of good communication in health care, and new laws
expanding the scope and detail of the information to which
patients are legally entitled have given additional public
currency to ethical theory.

The concept that good health care must be based in good
communication is radical, for doctors through history have
specifically avoided open exchanges with their patients;
traditionally, physicians placed little value in their
patients' comments and seldom shared information with them.
Although doctors have customarily asked patients to describe
their symptoms, often they have been skeptical of these
reports, and have tried to limit them as much as possible.
The Hippocratic physicians found patients' testimony to be
inaccurate, incomplete, and misleading [Chadwick & Mann,
1950; Lain Entralgo, 1969]. Others later complained that
patients often lied outright [deVillanova, 1946]. The
American Medical Association's 1847 Code of Ethics
proclaimed that patients' subjective interpretations did not pertain to diagnosis or treatment, and declared it to be the patient's duty to limit personal remarks to answering direct questions [AMA, 1847]. In the twentieth century, the development of diagnostic technology that seemed precise, objective, and reliable in contrast to the patient interview only increased physicians' doubts about the value of patient reports [Reiser, 1978a; 1978b]. The modern medical history has often resembled an expanded check-list which objectivizes information and eliminates the patient's opportunity to include details or personal meaning [Broadman, Erdmann, & Wolff 1949; Weller, 1979].

Moreover, historically physicians have given little information to their patients; the writings of physicians since ancient Greece are replete with exhortations against informing patients about their conditions. Instead, doctors have recognized an obligation to practice "therapeutic deception" in which they give orders and provide comfort, but withhold or misrepresent unpleasant news that might provoke anxiety and despair [Bok, 1978; Chadwick & Mann, 1950; Collins, 1927; Faden & Beauchamp, 1986; Katz, 1984; Kelly & Friesen, 1950; Percival, 1849]. The AMA's 1847 Code of Ethics declared that the physician had a "sacred duty" to withhold negative information from patients [AMA, 1847]. In the 1960s, and as late as the 1970s, psychiatrists Donald Oken and Elisabeth Kübler-Ross documented that physicians
rarely disclosed the diagnosis of serious illness to their patients, for fear that the news itself might kill them [Kübler-Ross, 1969; 1975; Oken, 1961].

Because doctors believed that discussion confounded diagnosis and impaired recovery, limited communication was traditionally understood to be for the patients' benefit, and physicians' silence was seen as evidence of their dedication to their patients' wellbeing [Faden & Beauchamp, 1986; Katz, 1984; Lain Entralgo, 1969]. Moreover, it was assumed that detailed conversation between doctors and their patients was unnecessary because doctors' professional dedication to others' health and their technical medical training gave them special knowledge about their patients' needs and the moral authority to make decisions for them. Physicians and philosophers in the Hippocratic tradition grounded medicine's morality in philia, the love of humanity; doctors motivated by philia were presumed to act on their patients' behalf and always in their best interests [Lain Entralgo, 1969]. Philanthropic physicians claimed that they could make the right choices for their patients without consulting them, in much the same way that a knowing, loving father could be trusted to make decisions for his children.

Medical philanthropy and the paternalism which it endorsed were accepted almost without question until only a generation ago, when the discovery of widespread medical
abuses pointed to patients' need for a greater role in determining what was in their own best interests. When the Nuremberg Trials revealed that physicians working in the name of medicine had committed horrendous crimes against the weakest members of society, it became apparent that despite medicine's moral claims, doctors did not always work on behalf of persons entrusted to their care [Ivy, 1947; Lifton, 1986; Nuremberg Military Tribunals, 1949]. The 1947 Nuremberg Code and subsequent 1964 World Medical Association Declaration of Helsinki proclaimed not only that it was essential for research subjects to consent freely to all procedures, but also that their consent was valid only if they were fully informed about the nature and purpose of the proposed experiment, including its potential risks and benefits [Nuremberg Military Tribunal, 1949; WMA, 1964].

Twenty years after Nuremberg, American medicine was rocked by physician Henry K. Beecher's revelation that perhaps as many as a quarter of all human studies conducted in the United States involved serious abuses of patients and subjects, especially in the area of disclosure and consent [Beecher, 1966]. The U.S. Public Health Service (PHS) and National Institutes of Health (NIH), the primary source of funding for American medical research, responded by mandating the creation of institutional review boards (IRBs) to oversee the treatment of human subjects within each funded institution [Curran, 1969; U.S. DHEW, 1966]. To
safeguard human subjects' right to disclosure and consent, the NIH required every research protocol to provide to each participant a formal consent document describing the proposed research and listing its significant risks [U.S. DHEW, 1971].

The silence fostered by philanthropic paternalism in medicine was further challenged in 1957 with the landmark malpractice case Salgo v. Leeland Stanford Jr. University Board of Trustees. Since the beginning of the twentieth century, courts had extended the application of assault and battery law into the medical relationship with a number of rulings forbidding doctors from operating without their patients' knowledge and consent [Katz, 1984]. In the Salgo case, Justice Bray of the California Court of Appeals ruled that physicians had a duty to their patients to make a full disclosure of the information necessary for them to give "informed consent" to treatment [Faden & Beauchamp, 1986; Katz, 1984]. While Bray did not elaborate on the meaning of the term, except to suggest confusingly that full disclosure be tempered with discretion, his formulation of the patient's right to choose and to the information necessary to make a considered choice was a landmark event for the modern medical relationship.

The phrase "informed consent" caught the imagination of theologians and philosophers already examining wider issues of social justice, and the Salgo decision fueled a growing
interest in the role and rights of patients. Theological ethicist Paul Ramsey, one of the first modern medical ethicists, publicly criticized medical paternalism as it affected both research and clinical practice, and sought to expand the patient's role in the doctor-patient relationship. Ramsey envisioned medicine to be a joint venture between doctor and patient, and insisted that the adult patient was due the physician's respect as a person capable of self-determination. Consequently, he maintained that informed consent was a universal requirement for ethical medical practice [Ramsey, 1970; 1971]; Ramsey identified consent as a "canon of loyalty" between the doctor and patient who were partners in what he referred to as a "covenantal relationship" [Ramsey, 1970].

The Ethics of Covenant, Contract, Communication, and Compassion in the Modern Therapeutic Relationship

The image of the medical covenant introduced by Ramsey was fleshed out five years later by theological medical ethicist William F. May in what has been called one of the most important works in medical ethics for its contribution to reshaping the ethical foundations of health care [May, 1975; Veatch, 1986]. Juxtaposing covenant and the traditional medical relationship, May condemned paternalistic medicine not only for its effects, but, more importantly, for the philanthropy on which medicine based its moral claim to paternalism. May sharply criticized the
assumptions of philanthropy-based medicine and challenged physicians to recognize the full dimensions of the love of humanity that medicine traditionally has proclaimed. Where philanthropy promoted silence, the covenantal model which he elaborated provided a powerful ethical basis for an expanded patient role in the therapeutic relationship and open communication in health care.

Much as the ethics of medical research were reformulated in response to the discovery of abuses against experimental subjects, May was prompted by the revelation of two doctors' serious breach of professional ethics to reexamine the traditional characterization of the philanthropic physician. He found that the ethical codes based on the ideal of medical philanthropy portrayed the doctor as a gratuitously generous individual who nobly accepted a life of service to the less fortunate, but who was totally self-sufficient and independent of his patients. May concluded that these codes assigned physicians a natural moral authority over the laity based on their greater knowledge, political power, and social worth rather than true moral superiority.

To May, the philanthropy which claimed the fulfillment of others' interests as its only end was not love at all, but rather an expression of medicine's pride and self-interest; thus philanthropy could not be an adequate moral basis for a medicine dedicated to others' wellbeing.
To base medicine's traditional assumptions in a true love for humanity, May, like Ramsey, turned to the Judeo-Christian image of covenant. Whereas philanthropy focused on the beneficence of the doctor to the patient, May argued that covenantal love recognized the value of the patient to the doctor and the mutuality of their relationship. May rebuked the medical profession for assuming that the giving within the medical relationship went only from physicians to their patients, and for failing to recognize doctors' debt to society and to their patients as individuals. Although doctors may be dedicated to the wellbeing of humanity, he insisted that they must recognize that the service which they provide is a gift which comes in response to the many sacrifices and investments made for them by others in the community. May identified this element of mutual gifts based in love as the essence of covenant, and the basis of a moral medicine.

May's work also provided a theoretical foundation for the expanded, active role that ethics and the law had recently assigned to patients. Like Ramsey, May believed that only the covenantal relationship properly recognized the equal moral worth of both doctor and patient, and found that in that relationship the patient becomes an active partner in the relationship rather than a passive recipient of the doctor's philanthropy. Such a patient is not only free to express his or her own needs and interests, but also
has a right to ask questions and receive information from the doctor. For May, the patient's active role is not merely a formal one; in a covenant, the patient has new responsibilities as well as new rights. Patients must bring a "will-to-life" and a "will-to-health" to the relationship as well as a desire for information and a need to be healed.

May later added a further dimension to the doctor's and patient's covenantal roles and the importance of good communication between them. Such a relationship, he asserted, demands that practitioners teach their patients as well as treat their ills, a duty consistent with the linguistic origins of the word "doctor" [May, 1983]. This teaching is unlike the simple orders or instructions traditionally given by the philanthropic doctor; teaching respects the patient's self-determination and intelligence, and requires that the physician listen with "moral imagination" to understand the patient's life circumstances and what he or she wants to know. Furthermore, the knowledge that teaching provides confers power on the patient, and enhances the patient's ability to be an equal partner in the relationship.

May's original essay was published at a time when the contractual medical relationship received wide attention from legal scholars in response to the development of informed consent law, and May also explored the abilities of the contractual relationship to fulfill the need for
reciprocity in medical care. While he found that a contractual model encouraged the full respect of the patient and relied on an open exchange of information, May argued that such a model could not provide an adequate moral basis for medicine [May, 1975]. May believed that a contractual relationship would reduce medical treatment to a minimalist commercial interaction, because in a contract both parties act only out of acknowledged self-interest, suppressing the element of gift that is central to medicine. Moreover, contracts include specific time limits which cannot provide the necessary room for change that could meet all of the contingencies of a medical encounter, and do not encourage longterm relationships in the way that covenantal medicine can.

May's insistence on the superiority of the covenantal model is to a degree a product of his theological perspective and symbolism; as a Christian theologian, he envisions the moral doctor-patient relationship to be a human approximation of the covenant between God and humanity. As May described, the ultimate focus of the covenant between God and God's chosen people is a promise which changes the nature of the covenanters and their relationship fundamentally: while their mutual promise includes specific duties, it also requires an ultimate fidelity to the covenant and to each other that transcends those duties. As an expression of that covenant, God
promises fidelity and constant presence to humanity; May sees in this image a moral basis for medicine's own traditional promise of fidelity to patients, a promise which a contractual model cannot sustain.

Essential to the promise of a covenant is the fact that even when one partner is unwilling or unable to to fulfill the specific duties which the covenant entails, the other remains bound by the general duty to fidelity. God's constant fidelity to individuals despite their failures comes in response to their fundamental value as covenantal partners, as the love on which the covenant is based endows them with an absolute worth and dignity apart from their actions or ability to act. Building on the early work of Ramsey, theological ethicists Stanley Hauerwas and Earl E. Shelp have used this covenantal image to understand medicine's traditional commitment to being with the ill, mentally handicapped, and dying at a time when their active partnership is limited by suffering or mental impairment, or when the possibility of cure is remote [Hauerwas, 1977; 1986; Shelp, 1984].

Hauerwas has noted that the suffering of the ill separates them from others in the community, both physically and existentially [Hauerwas, 1986]. While he recognizes that physicians are able to remain present to their patients because their specialized technical knowledge allows them to "do something" for the sick which others cannot, Hauerwas
believes that doctors' true activity is characterized by their traditional dedication to being present to those in need, even when nothing else can be done to help them. This commitment implies that the patient need not be capable of fulfilling the specific duties of patients generally in order to be a patient whom covenantal medicine values and whose best interests it seeks. The presence of doctors to such patients, like God's presence to all sufferers, affirms the value of all who need the doctor's care.

Shelp similarly finds the concept of the physician's presence to be an important corrective to the symbol of the doctor as an all-powerful healer. Many of the popular visions of medicine portray the doctor only as a source of cure, belying the fact that the physician's duties do not end when cure is not possible. Shelp maintains that the image of the doctor as a "sustaining presence" allows for both a recognition of medicine's strengths and an emphasis on the physician's fidelity to patients even when active treatment offers little hope of benefit [Shelp, 1984]. Although doctors can promise little with certainty, their covenant with patients offers the security and sustenance of presence that is essential to human wellbeing.

The concept of medicine as presence has significant bearing on the issue of communication in the therapeutic encounter that extends far beyond the formal exchange of information. The covenant which recognizes the
unconditional value of both partners establishes what theologian Martin Buber has called the "I-Thou" relationship, in which communication is the primary act of relating [Buber, 1970]. Buber claimed that two beings encounter each other person to person in conversation or dialogue, and that their relationship is created spontaneously as it flows through their communication. In true communication, each is wholly present to the other, and the speaker's attention is focused entirely on the partner [Buber, 1970; Kohanski, 1975]. True dialogue cannot be demanded; like all aspects of a covenantal relationship, it is a gift which comes in response to the other, and which affirms the love of one being for an other, even when the one who receives the gift is unaware of that love.

Although Buber held that communication as knowledge of and presence to the other is possible without spoken conversation, Jesuit linguist Walter Ong maintains that the truest form of human presence is speech [Ong, 1967; 1982]. Because sound signals activity, the spoken word conveys a personal, active presence as nothing else can. Ong has stressed that human encounters exist through voice, and that the spoken word binds individuals together. Oral communication creates a shared awareness by uniting separate persons in a common experience of sound. Ong's conclusions give communication between doctor and patient a central role in a covenantal medical relationship: doctors best fulfill
their commitment to the covenantal ideals of medicine when they maintain good communication with their patients, for they are most present to their patients when they talk with them.

The relationship of physician and patient as strangers: communication as the basis of the medical contract

Although the image of the covenant between doctors and their patients has fundamentally theological roots, the term "covenantal relationship" is not exclusive to theological medical ethics. The phrase has been adopted as well by philosophical medical ethicists who, likewise rejecting philanthropy as a morally inadequate basis for medicine, propose a contractual medical model in its place. However, the two leading proponents of the contractual model, philosophical ethicist Robert M. Veatch and physician-philosophical ethicist H. Tristram Engelhardt, Jr., hold that the difference between contract and covenant is largely a semantic one [Engelhardt, 1986; Veatch, 1981, 1986]. Both insist that a covenant is only a special kind of ongoing contract with the same essential characteristics and goals as other contracts. A medical contract, Veatch has insisted, is similar to the covenantal "marriage contract" which is longterm and open-ended, and which requires no reference to God [Veatch, 1972; 1981; 1983; 1986].

Veatch and Engelhardt rejected the philanthropic ethic because it continued to assume that the physician was the
best interpreter of the patient's interests even after the social revolution which had placed new emphasis on individual rights and values. However, their focus differs from that of May, Shelp, and Hauerwas, who concentrate on the values that bind doctor and patient together in pursuit of the patient's best interests; instead, they examine the factors which make unreasonable the assumption of friendship and mutual goals between physicians and patients. Both Veatch and Engelhardt have observed that, in contemporary American medicine, doctors and their patients often vary greatly in ethnicity, class, economic level, and religion, and their respective backgrounds may give them few common values on which to build a relationship. They have proposed the contractual or covenental model of social relationships for medicine as a means to accommodate different values and expectations: in a contractual relationship, the rights and duties of the physician and patient at every level are negotiated, not presumed [Veatch, 1972; 1981; 1983; Engelhardt, 1983, 1986].

Veatch maintains that persons in any relationship are parties to three separate contracts which must negotiated: 1) the basic social contract that defines the larger moral community; 2) the contract that provides the moral framework for relationships between members of that society -- such as doctors and patients -- in general; and 3) the contract that defines the relationship between two parties as individuals
[Veatch, 1981; 1983]. While such negotiation is most easily worked out between members of a single community with a common moral understanding, Veatch argues that the value of the contractual medical relationship is that the patient and physician need not be friends for medical interaction to take place.

Veatch recognizes that a great deal of modern health care is delivered in situations which do not permit the formation of medical friendships or even longterm doctor-patient relationships, encounters where the patient and physician meet as strangers who will never meet again. While it is impossible for a philanthropic physician to provide moral medical care to a patient who is not a friend -- as the physician may not recognize what the patient believes to be his or her best interests, Veatch maintains that a moral medical relationship between strangers is possible under the contractual ethic. In such a relationship the third contract is deemphasized, and increasing significance is given to the second, defining the social roles of doctors and patients generally. Their interaction must be open and based on a willing exchange of information; when the doctor has no specific knowledge of the patient as an individual, the second contract requires that he or she give the patient such information as a reasonable, objective person would want to know.

While Veatch has focused primarily on the medical
relationship between social strangers, Engelhardt has argued that the situation is often even more complex: in a pluralist society such as the United States, doctors and patients may meet in medical encounters with little or nothing in common [Englehardt, 1982; 1983; 1986]. In some cases, the pluralism within American society creates divisions even within the most basic first contract, defying attempts to define a single community in any traditional way; patients and physicians may be strangers at every level. Although strangers may have no common moral sense to which to appeal in resolving a moral claim, in contractual medicine patients and doctors can negotiate the boundaries of their relationships from among the variety of competing viewpoints. Between strangers explicit communication about goals and values is essential, for without it they may never be aware of the scope of their differences, and they may harbor vastly different expectations of their relationship and the medical care that will be provided.

Engelhardt's contractual model values communication not only as the means to identify and resolve differences between strangers, but more importantly, as the procedural guarantee that the autonomy of both parties will be respected by the other. Without a discussion of their individual moral and conceptual frameworks and a thorough disclosure of the proposed treatment and its implications, the doctor, the patient, or both may find themselves forced
to honor unexpected and unacceptable decisions made by the other. The contractual medical relationship between strangers is thus founded on free and informed consent based in an open exchange of information and a mutual expression of self-interest.

For Englehardt, the focus of informed consent is on the procedure of negotiation itself, through which the content of the relationship is determined. Although Englehardt assumes that the contracting patient is capable of asserting his or her own interests, he has insisted that the physician must promote and safeguard the procedures of fair negotiation to ensure that the resulting treatment decisions represent both the true, informed choices of the patient, and the doctor's own wishes [Englehardt, 1983; 1986]. This responsibility is the physician's because the patient is likely as much a stranger to the procedures of medicine as to the doctor. Nonetheless, while the physician is an authority in medicine, adequate disclosure cannot be defined by the practitioner in advance; its adequacy is determined instead according to whether the patient has sufficient information to choose freely [Engelhardt, 1983]. Thus, the more the doctor and patient are strangers to each other, the greater their need for detailed communication to guarantee the patient's free and informed consent.

Engelhardt's formal contract places a vital new emphasis on the ethical role of communication in the
therapeutic relationship by stressing need for an increased exchange of information between strangers as the basis of their relationship. However, this added stress comes at great cost to the traditional moral commitments of medicine: good communication between doctor and patient is only a procedural guarantee of their right to respect as persons within the contract, and is no longer a reflection of the physician's dedication to the patient's needs. In such a contractual relationship a physician is no longer dedicated to relieving human suffering for the sake of the sufferer. Contractual medicine recognizes its only duty to patients to be the protection of their autonomy, irrespective of how such action affects their wellbeing.

Engelhardt's depiction of contractual relationships never fully addresses the question essential to understanding medicine's traditional value system and the moral basis of the therapeutic relationship: why the "helping professions" are dedicated to helping. While self-interest is clearly one factor motivating health care professionals to choose a life of service, self-interest alone cannot explain medicine's traditional dedication to those patients who are mentally retarded, mentally ill, senile, or comatose. Such individuals are not capable of the moral autonomy on which Engelhardt's vision of respect for persons depends, and their care usually results in few of the benefits of service for caregivers. Only the
willingness to give freely of oneself, the essence of covenant, supports the commitment to presence that offers such patients the promise of wellbeing.

Philosopher Coleen Clements and her physician colleague Roger C. Sider have argued that contractualism abandons the entire value system of medicine, leaving the medical relationship without ethical content [Clements, 1984; Clements & Sider, 1983]. Thus, they claim, Engelhardt's vision of autonomy and emphasis on the formal process of informed consent are reduced to ethically meaningless tautologies. Although the "biological bottom line" of function and adaptation which Clements and Sider offer as the measure of patients' best interests itself tends toward paternalism, their critique of contractual medical relationship is well directed. As May contends, the contractualism which places self-interest and autonomy as its primary guides reduces medicine to a commercial enterprise in which the needs of the patient are morally compelling only for the physician who chooses to meet them.

The consequences of absolute contractual medicine for doctors, patients, and medicine as a profession, and the fundamental ethical importance of medicine's dedication to patient wellbeing, are currently being played out as the health care system faces a growing number of persons with AIDS or HIV infection. Under the contractual model of medicine, the physician is free to refuse to treat persons
who are HIV-infected, a liberty supported by a provision in
the AMA's 1957 code of ethics that gives the physician
freedom to choose whom to serve [AMA, 1957]. Threatened by
a perceived risk of infection, many physicians have invoked
this provision, refusing to treat HIV-infected persons [Dan,
1987; Staver, 1987].

Physicians Abigail Zuger and Steven H. Miles have
suggested that AIDS provides valuable lessons on the ethical
commitments of medicine that physicians of the past 40 years
have forgotten [Zuger, 1987; Zuger & Miles, 1987]. Whereas
contemporary doctors may insist that they have no
contractual obligation to persons infected with HIV,
especially inasmuch as treating them may involve personal
risk, Zuger and Miles observe that until the advent of sulfa
drugs, physicians accepted the risk of contracting a fatal
infection from their patients every time they went to a
bedside. Doctors' willingness to hazard their own illness
and death from daily contact with the sick clearly
demonstrated their sense of duty to self-sacrifice over
self-interest, and to presence over freedom. Physicians'
dedication to their patients stemmed from a virtuous love of
others rather than from contractual obligations.

Zuger and Miles recognize that medical virtue was
tested whenever epidemics posed a serious threat to the
physician's life. Yet, when physicians abandoned their
practices in the face of rampant infection, doing so cost
them the very foundation of their enterprise: the public's trust in the profession as a whole. Zuger and Miles suggest that an impending consequence of contemporary physicians' refusal to treat HIV-infected patients will be just such a loss of public confidence. Doctors' eager acceptance of their contractual freedom to refuse AIDS patients has already left society unable to meet its citizens' need for health care, health care which has been confirmed as a right by legislation [President's Commission, 1953; 1983]; the abilities of emergency room physicians and residents in public health care institutions, who alone have a contractual obligation to care for patients infected with HIV, are already overwhelmed. As Zuger and Miles report, public condemnation of physicians' unwillingness to treat HIV-infected persons has already begun, and is likely to become only more vocal and more damaging to the profession [Anonymous, 1988].

Although in the contractual model of medicine the profession as a whole is recognized to have a duty to the sick, Zuger and Miles reject contractual medicine because it imposes no specific obligations on individual physicians. Zuger claims that the residents who are now being forced to confront AIDS are learning important moral lessons about medicine as the practice of individual virtue that it used to be. Not only will these residents know what it means to meet the challenge of self-sacrifice, they will understand
the value of counseling and reassurance when such presence is all that medicine has to offer [Zuger, 1987]. These moral skills, more than any technical knowledge, will make the current generation of residents valued by the public and valuable to the profession.

Zuger and Miles insist that AIDS will force the medical profession to come to grips with the limitations of contractual medicine. They suggest that the AMA's unprecedented affirmation in the 1847 code of ethics that physicians had a duty to alleviate suffering, even at the jeopardy of their own lives, was due more to a need to establish the professional honor of medicine than to any hope of conquering infectious diseases. Similarly, Zuger and Miles believe that a professional reaffirmation of the individual physician's dedication to anyone in need is the only way to restore the trust upon which ultimately even scientific medicine is based. Just as the 1847 formalization of the physician's professional obligation to the suffering resulted in medical heroism in subsequent epidemics, so too, they hope, will a reaffirmation of individual duty result in a return to virtuous behavior in the current medical crisis.

In elaborating the individual physician's duty, Zuger and Miles place significant emphasis on an understanding of "profession" that finds its roots in the concept of a commitment that carries obligations. In the case of
medicine, the commitment is to healing persons in need of care; its obligations include the virtues that may be necessary to provide that care. Zuger and Miles hold that an individual who voluntarily enters the medical profession assumes its commitments, and thus cannot exercise the liberties afforded by contractualism without betraying the profession. This conclusion has also been drawn by physician and medical ethicist Edmund D. Pellegrino, who has insisted that upon entering the profession of medicine, the physician makes a public avowal of commitment to the wellbeing of others, a commitment which creates ineluctable moral obligations which do not accommodate many of the contractual model's freedoms [Pellegrino, 1978; 1979; 1987].

These claims for virtue in medicine, however, still raise questions about the source of medicine's commitment to others' wellbeing. The presupposition made by May, Shelp, and Hauerwas that the transcendent presence of a covenantal God of love lies behind the physician's commitment to presence is an attractive theological answer, but it fails to meet the challenge of moral pluralism. Appeals to the Judeo-Christian concept of agape which theological ethicists use to support a renewed call for presence would be little motivation for either secular physicians or those of other faiths. Essential to a complete understanding of the ethical therapeutic relationship is a clearly articulated basis for presence which neither relies strictly on
theological language, nor denies the validity of religion as a source for ethical inspiration.

This problem is not wholly new: Ramsey recognized as early as 1970 that before it could resolve any other question, the new medical ethics required a single term which could express the essence of the health professions and describe the ultimate moral requirement of all who offered help to the suffering [Ramsey, 1971]. He sought a word that would place medical ethics within the arena of ethical discussion generally but which would not be dependent upon other systems of decision-making, particularly religious systems, for its meaning. Reflecting the vision of physician Francis Peabody, Ramsey suggested the word "care" as the ethical term strong enough to serve both as a source of specific moral obligations and as the ultimate measure of right and wrong [Peabody, 1927]. Care, as Ramsey understood it, was not simply medical care, but a respect for human life that could take its place alongside Jewish fidelity or hesed and Christian love or agape.

Ramsey's concern to distinguish between "caring for", which is motivated by compassion and mercy, and "taking care of", which focuses on actions that may be motivated by many factors, was well founded. Today the ethical implications of care have been overpowered by the very technical sense that Ramsey sought to avoid; in the "intensive care" unit, for example, care in Ramsey's first sense is secondary to
technical intervention. Although Ramsey insisted that care be differentiated from "cure" [Ramsey, 1970], the word's inherent double meaning continues to support the assumption that medical intervention is the primary form of care. Today there is limited appeal to "care" as a principle upon which to base the ethics of the health professions, because the image that it invokes is technical, not moral. Moreover, in the past few years, "patient care" has come to be used interchangeably with "patient management", a phrase whose emphasis on control reintroduces the old assumptions of medical paternalism [Dickey, 1986; Miller, Weber, & Green, 1986; Sheps, 1987].

Throughout the history of ethical discussion in medicine, however, one term appears repeatedly as a moral quality essential to medical care and the physician's relationship to patients: "compassion". Whereas the concept of care offers conflicting indications about professional duties, compassion has a depth of meaning that illuminates the nature of the therapeutic relationship and its corresponding obligations. "Compassion" is linked philologically with "patient"; as Pellegrino has traced out, both are derived from the Latin root patior, meaning "to suffer" [Pellegrino, 1978]. Compassion entails experiencing and bearing the suffering of another, and the desire to alleviate another's distress. The compassionate physician is one who suffers with the patient and is motivated to
relieve that suffering.

**Compassion in health care: the professional standard**

Compassion is well suited as an expression of the basic commitment of the health care professions and the foundation of the therapeutic relationship on several grounds. Compassion is able to face the challenge of pluralism as one of the most important ethical attributes across the major religious and cultural traditions. In Christianity it is recognized as a vital expression of *agape*, the basis of the covenental relationship. Judaism likewise understands compassion as a human expression of the image of God [Borowitz, 1986], and Jewish physicians are encouraged to treat their patients with excellence in compassion as well as in clinical skill [Gordon, 1983]. The Moslem dedication to hospitality and almsgiving comes as an expression of compassion for the stranger in need [Donaldson, 1953; Robson, 1970]; Islamic medical ethics, also based in the Hippocratic tradition, insists that the doctor reflect God's compassion in treating patients [Levey, 1967]. Bhakti Hinduism similarly recognizes human compassion to be a reflection of God's love, while the Jnana tradition includes it as one of the soul's highest aims and a component of the love of Supreme Self [Smart, 1970]. For Buddhists compassion is one of the four universal virtues and the fundamental attitude behind all good behavior [Ling, 1970; Smart, 1986]. In the western philosophical tradition,
compassion has been called the basis of morality, although its source remains a mystery [Blum, 1980; Schopenhauer, 1965].

Of particular merit, however, is the fact that throughout history physicians themselves have recognized compassion as one of the doctor's most essential attributes [Amundsen & Ferngren, 1982; 1985; Ferngren & Amundsen, 1985; Pellegrino, 1985]. In the past 15 years medical schools across the United States have instituted programs in medical ethics and human values in a concerted effort to promote compassion among medical students [Cohen & Soloway, 1984; Dankmeyer, 1984; Holden, 1984; Hunter, 1984; Pellegrino et al., 1985; Pence, 1983]. In 1983, the American Board of Internal Medicine formally declared that all residents seeking certification would be required to demonstrate high standards of compassion in their professional lives, and the Board identified several areas in which medical education and residency programs should foster the development of compassion in young doctors [ABIM, 1983; Lipkin, 1986]. Just this year, as Zuger and Miles predicted, the AMA affirmed that the profession's dedication to compassion demanded that physicians treat persons infected with HIV [AMA, 1987]. The traditional importance of compassion within the profession gives it significant advantages over ethical standards imposed from the outside.

Critics of virtue-based ethics in general and
virtue-based medicine in specific have claimed that qualities such as compassion are not adequate standards for moral behavior because seeking virtue as an end may facilitate and even promote wrong acts [Veatch, 1985]. Compassion, for example, might motivate mercy killing or lead caregivers to overlook issues of resource allocation and duties to others in treating patients whose problems are particularly compelling [Kopelman, 1985]. However, such analyses depend on a simplistic understanding of a complex phenomenon. Compassion is more than sentiment or inclination, and compassionate actions need to be rational, informed, and effective as well as beneficent [Blum, 1980; Glick, 1985]. More importantly, as true compassion is an experience of shared humanity, even between strangers, it promotes the acknowledgement of human equality and thus respect for the autonomy of the sufferer [Blum, 1980]. Critics wrongly contend that compassion leads to paternalism [Veatch, 1985], for compassionate concern recognizes that there are situations in which seemingly beneficent action may be inappropriate and where presence is all that is truly called for. Moreover, compassion for another in need can be the basis for a relationship between strangers with little else in common.

Although compassion once served as a rationale for silence and deception, medical ethics' recent conceptual revolution has demonstrated that true compassion demands
good communication in the therapeutic relationship. The compassionate professional communicates openly with patients in order to know them as persons whose values and individual experiences shape their interaction, to share the information that allows them to retain the autonomy which human dignity demands, and to provide them with the human presence that is the essence of compassion and the foundation of medical care. As Pellegrino has described, the "consent" which depends on open communication is an emotional, physical, and intellectual sharing between doctor and patient for which compassion is indispensible [Pellegrino, 1978].

Both Pellegrino and Zuger and Miles assert that virtue-based medicine and contractualism can coexist if compassion (and/or other virtues) is the professional standard of excellence within contractual medicine. This professional standard would reflect the moral aspirations and ideals of medicine rather than the mundane demands of self-interest [Pellegrino, 1987; 1988; Zuger & Miles, 1987]. Their confidence that compassion can inspire physicians to ethically superior behavior is supported by medicine's historical tradition as well as contemporary experience. However, like May's and Hauerwas' single emphasis on the role of Christian love in medicine, such enthusiasm for the motivational power of human virtue obscures the real, simultaneous need for the minimum standards set by
contractualism and the importance of a system of coercive justice.

Where the contractualists give too little credit to the human capacity for altruism, the proponents of virtue fail to recognize that compassion, like love, is ultimately an ideal never fully attainable in medicine or any other human endeavor. Inherent even in the Judeo-Christian love commandment is the recognition that no one can live up to the standards that God sets, and that human relations are never characterized by the love of God or neighbor alone. Physicians are not infinitely capable of compassionate service to all persons, and occasionally they may be called to treat patients who evoke in them extremely negative reactions [Gorlin & Zucker, 1983; Merrill, 1988]. Doctors who fail to recognize the limits of their compassion, like the traditional physicians who saw no limit to their philanthropy, may further impair their ability to work on behalf of difficult patients.

Because no doctor can provide infinite compassionate presence or know from shared experience what factual information each patient wants and needs, contractual negotiation and formal consent remain important elements in every therapeutic relationship. In a world of limitation and imperfection the procedural safeguards of contractualism are an expression of justice that approximates the standards of professional excellence and the ideals of divine love or
perfect virtue. While Hauerwas contends that the God who wills persons to be present to others in illness would not coerce that presence from physicians [Hauerwas, 1986], minimum contractual requirements for communication between doctor and patient guarantee that medicine as a profession can continue to serve all persons in need of health care, even when virtue does not motivate the individual physician to care for a specific patient.

The conflict over which model of medicine should prevail reflects the contradictions inherent in human life; both goals and minimum standards are necessary for moral behavior in the therapeutic relationship just as in all human activities. The relationship between strangers who come together in a medical consultation is enriched by compassion, but when compassion is not possible, the relationship can be preserved and even strengthened by the respect for human dignity that contractual negotiation demands. Contractual medicine and covenantal medicine can and must coexist. Medicine's covenantal promises and contractual obligations supplement each other, supporting physicians' dedication to others' well-being, acknowledging individual autonomy, and fulfilling the human need for presence much more fully than either can alone.

**Non-physician views on communicating with hospital patients**

The radical changes that have occurred in the ethical perspective on medical relationships have been accompanied
by similar redefinitions of patient-caregiver interaction in the perspectives of other health care professions.

Motivated by moral presuppositions about autonomy and respect for persons, increased efforts toward professionalization, and growing concern with consumerism, nursing and the allied health and social service professions have placed increasing emphasis on the importance of humanistic health care and the role of communication in responding to every patient as an individual.

By far the most sweeping developments have come in nursing, with scores of books and hundreds of articles on nurse-patient interaction and communication written in the last decade. One of the most obvious indications of the change in the conceptual framework of nursing is symbolic: nursing has officially rejected the term "patient" in favor of the term "client" [ANA, 1976]. The change was made to reflect contemporary nursing's philosophical understanding of the persons whom they treat: nurses maintain that while "patient" connotes dependence on a parental caregiver, in its common usage if not in its roots, "client" implies independence and a relationship based on respect for the right of self-determination [ANA, 1976; Bradley & Edinberg, 1976; Collins, 1977].

Nurses' adoption of the term "client" has accompanied a movement toward greater professionalization in nursing, and contemporary nursing literature identifies the nurse's
role as not only meeting patients' specific health needs, but also as serving as an advocate or ombudsman for them [Bradley & Edinberg, 1976; Collins, 1977; D.S. Davis, 1986; Edwards & Brilhart, 1981; Kohnke, 1982; Lindberg, Hunter, & Kruszewski, 1983; Theis, 1986]. As the patient's advocate, the nurse is charged with upholding the patient's specific health care rights, such as those listed in the American Hospital Association's (AHA) Patient's Bill of Rights [AHA, 1973; Countryman & Gekas, 1980], as well as investigating complaints, resolving problems, and facilitating communication with other members of the health care team [Edwards & Brilhart, 1981; Kohnke, 1982; Lindberg, Hunter, & Kruszewski, 1983].

Nursing's emphasis on communication is especially directed toward knowing the patient as a unique individual. Nursing literature on communication stresses that although nurses and their patients meet as strangers, nurses must come to know each patient's socioeconomic and ethnic background, and personal history in order to understand his or her perception of illness and hospitalization and provide individualized care [Edwards & Brilhart, 1981; Dult, Giffin, & Patton, 1984; Fritz et al., 1984; Lewis, 1978; Lindberg, Hunter, & Kruszewski, 1983; Theis, 1986]. It is also important for the nurse to recognize and understanding these characteristics because they help to explain the patient's values and interests which, as the patient's advocate, the

Although the word "contract" is not used in the nursing literature, there are several similarities between the relationship of the patient and nurse as advocate and the contractual medical relationship described by Engelhardt. In each the caregiver recognizes and respects the patient's individuality and autonomy. In each the professional emphasizes good communication with the patient, both out of respect for the patient's autonomy, and as a means of identifying his or her personal history, values, and interests, which are recognized to contribute significantly to care. In each the professional is dedicated to ensuring that these interests are protected and served to the best of the caregiver's ability.³

Nursing, like medicine, also has a tradition of emphasizing compassion. A few recent examinations of the nurse-patient relationship claim that good communication is essential to compassionate care, and suggest a link between compassion and advocacy [Cowart & Reading, 1981; Dult, Giffin, & Patton, 1984]. Such proponents of good communication in nursing recognize its existential nature, its humanizing effects on interpersonal relationships, and its ability to create the human presence essential in critical life situations. Although they do not use the
language of covenant, nursing educators Bonnie W. Dult, Kim Giffin, & Bobby R. Patton suggest that Buber's I-Thou relationship should be the model for nurse-patient interaction [Dult, Giffin, & Patton, 1984]. Unfortunately, however, because their increasing professionalization has led nurses to separate themselves philosophically from physicians, and as nursing ethics has developed apart from medical ethics, there has been little meaningful dialogue between the proponents of the covenantal, contractual, and advocacy models of health care.4

Whereas nursing's attention to the patient's individuality and personal characteristics is a relatively recent phenomenon, social workers' interests in the nonphysical aspects of illness dates to the turn of the century and the origins of their profession. Social work presupposes that socioeconomic, ethnic, psychological, and emotional factors contribute significantly to illness -- what is known today as the biopsychosocial model of health [Engel, 1972], and that to treat a disease effectively it is necessary to know the nonmedical background of the patient. The social worker's job is not only to discover how such factors influence individual patients' conditions, but to help them overcome or work around negative factors to achieve social as well as physical wellbeing [Butrym, 1984; Cabot, 1919; Cannon, 1952; Germain, 1982; Ratliff, Timberlake, & Jentsch, 1982]. Contemporary social work's
growing emphasis on psychological counseling is an outgrowth of this biopsychosocial model [Germain, 1984; Ratliff, Timberlake, & Jentsch, 1982; Wallace, Goldberg, & Slaby, 1984]. Whether psychologically or medically oriented, social work relies heavily on good communication with patients to assess patients' needs, teach them healthful behavior, and motivate them to achieve good health [Butrym, 1984; Cannon, 1952; Germain, 1984; Wallace, Goldberg, & Slaby, 1984].

Although social workers have recently adopted the term "client" as an expression of their respect for the autonomy of the patients with whom they work, this is not a new sentiment. Since the birth of their profession, social workers have emphasized that their true duty is to help autonomous others learn to help themselves to become and remain healthy [Cabot, 1919; Cannon, 1952; Germain, 1984; Wallace, Goldberg, & Slaby, 1984]. They have long recognized that their work brings them into contact with people of limited means and education -- strangers with vastly different backgrounds, and that if they are to help those who need it most, they must be neither judgmental nor paternalistic [Cabot, 1919; Cannon, 1952]. The goals of social work are based in the Judeo-Christian vision of morality, due in no small part to the fact that its founder, Richard C. Cabot, was a theological ethicist as well as a physician [Butrym, 1984; Cabot, 1919; Cannon, 1952]. The
therapeutic relationship that social workers seek with their patients is quite similar to May's covenantal relationship.

The clergy, whose tradition of working with the sick is as old as that of even physicians, have long recognized that physical disease is accompanied by nonphysical ills. In the modern professional role of hospital chaplain, the clergy address the spiritual needs of hospital patients from the perspective that health and illness are holistic concepts that require holistic care [Dobson, 1973; Holst, 1985; Knights, 1977]. Hospital chaplaincy has been described as a "ministry of dialogue" [Holst, 1985], and in all of the clergy's many functions in the hospital, good communication is both their primary work and principal tool [Carey, 1985; Holst, 1985, Mitchell, 1966; Wheelock, 1975]. As in social work, the emphasis on this dialogue has often led chaplains into psychological therapy as well as spiritual counseling [Knights, 1977], yet the fundamental role of communication has not changed.

Where other professionals in the hospital have made the change to "client", chaplains are content with the term "patient", and recognize its roots in the concept of suffering [Holst, 1985]. The acknowledgement of the moral equality of patients and their caregivers is nothing new to the clergy, whose religious commitment to service is based on that belief, and the financial implications of the term "client" have little to do with the interaction between the
clergy and those whom they serve. The hospital chaplain's "parish" is a congregation of strangers who often reveal their true selves to the chaplain more readily than to any other member of the hospital staff [Holst, 1985]. As in all situations in which the clergy provide comfort in the face of human suffering, the relationship between the chaplain and patient is fundamentally covenantal, as the chaplain formally represents the presence of God [Knowles, 1977].

Among the newer specializations of allied health care, a few professions also advocate greater recognition of nonmedical factors in treatment and actively promote fuller communication within the "client-professional" relationship. In dietetics, literature on dietician-patient interaction stresses the importance of good communication for three phases of care: assessing personal background and dietary history and needs, assessing whether individual patients are capable of making their own choices, and facilitating patient independence in the selection of foods [ADA, 1982; 1985; Holli & Calabrese, 1986; Mason, Wenberg, & Welsh, 1982]. Dieticians place an especially heavy emphasis on Carl Rogers' "client-centered counseling", a process which requires that they learn about their patients' individual backgrounds and values in order to empathize with them [Rogers, 1951]; without such empathy the dietician is unable to help the patient understand his or her problems or promote change [Holli & Calabrese, 1986; Mason, Wenberg, &
Similarly, physical therapists insist that good communication with patients is essential to their profession because they work with the whole person, whose life experiences, characteristics as a social entity, and personal expectations shape treatment needs as much as his or her physical disability [C.M. Davis, 1986; Hollis & Yung, 1985; Payton, 1986]. The communication skills necessary to identify the depression and frustration that disabled patients often experience are especially important to therapists [Lewis & Schaefer, 1986; Payton, 1986]; and because disabled patients must often take an active role in treatment, the therapist must be able to teach and motivate them to overcome their negative emotions and participate fully in therapy [Ramsden, 1986].

There has been some exploration of the themes of patient autonomy and professional paternalism in both dietetics and physical therapy, yet the discussion of these issues has focused on their value as therapeutic tools, not as moral principles [Davis, 1986; Holli & Calabrese, 1986; Mason, Wenberg, & Welsh; 1982]. Professionals in both fields advocate respect for patient autonomy because allowing patients to make their own decisions promotes the self-esteem and independence that is essential to their full recovery, whereas paternalism inhibits such growth [Davis, 1986; Holli & Calabrese, 1986]. While these motives for
respecting patient autonomy and encouraging good
communication are valuable in a practical sense, neither
dietetics nor physical therapy has articulated the moral
basis of its professional relationship with patients in the
way of nursing, social work, or hospital chaplaincy.

One of the newest patient care professions to address
the issue of professional relationships and communication
with patients is that of the patient representative. In
many hospitals and some large clinics, the patient
representative, sometimes known as the patient ombudsman or
advocate, is the official liason between the institution and
the patient, whose primary responsibility is to humanize the
patient's experience of the institution [Mailick, 1984;
Patient representatives may be nurses or social workers, but
more often they are neither. The role was developed
originally by individual hospital administrations in
response to increasing consumerism in health care, but in
the early 1970s the AHA encouraged the widespread
development of patient representative services. With the
formation of a national society of patient representatives,
the field has experienced increasing professionalization

The patient representative may be called upon to act in
many capacities, each of which requires the ability to
communicate well: as a facilitator of communication between
patients and caregivers; as an intermediary between the patient and administrative branches of the institution; as a risk management specialist who can resolve a complaint before it becomes litigation; or a counsellor who listens to patients' troubles when no one else has time to do so [NSPR, 1978; 1981; 1985; Rehr & Ravich, 1981]. Since the early 1970s, when the AHA and the Joint Commission on Accreditation of Hospitals (JCAH) issued their respective statements on patients' rights, patient representatives have emphasized their role as the protectors of those rights, and the advocates of patients' interests [AHA, 1978; JCAH, 1976; NSPR, 1985; Rehr & Ravich, 1981]. Patient representatives often see themselves as "culture brokers" who facilitate ethical health care among strangers by ensuring that the patient and staff understand the value system of the other [NSPR, 1985].

Although patient representatives focus a great deal of attention on patients' rights and values, their discussion of patient autonomy is dominated by a view of patients as consumers. The National Society of Patient Representatives finds that both the terms "patient" and "client" imply a relinquishing of autonomy to professionals, while "customer" or "consumer" suggests the independence of choice which accompanies buying a service [NSPR, 1985]. Hospitals' use of patient representatives to maintain good customer relations is demonstrated by the fact that many patient
representative services are known as the "patient relations department" [NSPR, 1985]. "Customer satisfaction" is ultimately as much the goal behind their pursuit of patient values as is a dedication to relationships grounded in moral principles.

It is clear from contemporary literature in nursing and the allied health and social service professions that there is almost universal interest in communication with patients and its role in the therapeutic relationship. Although the trend toward recognizing and respecting patient autonomy appears to be growing as well, unfortunately, not all of the professions which now emphasize patient individuality have incorporated ethical theory into their analyses of therapeutic interaction; recognition of any real moral basis for their proclaimed dedication to patients is conspicuously absent. Many of the proponents of respect for patients' values and enhanced communication with patients appear to use the language of ethics primarily in an effort to further their claims of professionalism, following the model of the physician, without articulating a true moral commitment to their patients.

Equally unfortunate is the fact that while the goals of the individual disciplines are remarkably similar, each is developing its own theories on communication in patient care as they seek to differentiate themselves from others through professionalization. Before increasing professional
jealousies make integration impossible, there is a pressing need to define the moral basis of all therapeutic relationships -- including the presumably disparate fields of medicine and nursing, which can provide a comprehensive theory of communication that accommodates the perspectives of each field.

Social science research into the nature of communication between strangers in the therapeutic relationship

Because even the work of ethics that is immediately applicable to the real problems of patient care is fundamentally interested in values over empirics, the ethical theory which extolls health care professionals' good communication with patients as a response to the patients' personhood has developed apart from practical consideration. However, ethical theory can find much support from social science, which has concluded over the last thirty years that good communication between patient and caregiver -- usually the physician -- is essential to successful health care. Social science, which claims to be value-free, nonetheless demonstrates that patients respond well to the kind of communication that satisfies the demands of ethics. Its research consistently illustrates ethics' claim that good communication builds and sustains therapeutic friendships even between patients and caregivers who start as strangers, while poor communication and disregard for the patient as a person can destroy a relationship in which satisfactory
technical treatment is provided.

The importance of communication between physicians and their patients for patient satisfaction with care and subsequent compliance with treatment has been demonstrated repeatedly in clinic and hospital settings and among patients of varied backgrounds. In a now classic study of the interaction between doctors and 800 first-time patients\(^5\) in a large, urban pediatric clinic, Barbara M. Korsch, Vida Francis Negrete, Ethel K. Gozzi, and Marie J. Morris found that there was a strong correlation between the doctors' communication behavior and the patients' satisfaction with their doctors and the care that they received [Francis, Korsch, & Morris, 1969; Korsch, Gozzi, & Francis, 1968; Korsch & Negrete, 1972]. Their study found that where the physician demonstrated a friendly, personal interest in the mother and she was able to ask questions, there was a high overall satisfaction with the encounters, the physicians, and the treatment that the children received. Conversely, mothers who believed that the doctors paid too little attention to their worries and who were given no opportunity to ask questions were dissatisfied with their doctors and their treatment. Moreover, good rapport appeared to lead to good compliance, while patients who complained about poor communication with their physicians were less likely to follow their advice [Francis, Korsch, & Morris, 1969; Korsch & Negrete, 1972].
Subsequent research in other contexts has demonstrated similar results. Linda Roter has shown that patients who are free to ask questions are more likely to find their doctors to be caring and responsive than are patients who are passive [Roter, 1977]. David Locker & David Dunt have concluded that patients from a variety of settings who report that their physicians communicate information and empathy well also report a greater overall satisfaction with their care [Locker & Dunt, 1978]. Maureen Reynolds has documented that British hospital patients who are dissatisfied with the extent of their communication with doctors are more likely to be anxious and fearful, and tend to recover slowly [Reynolds, 1978]. Phillip Ley has shown that the complaints of Australian clinic patients about poor communication correlate strongly with their dissatisfaction with their physicians and a poor rate of compliance with recommended treatment [Ley, 1983; 1985]. Precisely how these authors or their subjects defined "good communication" is not fully clear from their presentations, although the quality of the physicians' communication behavior is alluded to by such concepts as caring, empathy, and the patients' negative responses of fear and anxiety.

Three studies which attempt to define the nature of good communication also link the conclusions of ethics and social science. In research conducted in a British general practice setting, David Pendleton identified several
components of good medical communication, including whether the doctor showed interest and concern for the patient, took the patient's complaints seriously, and reassured the patient about the outcome of treatment [Jaspars, King, & Pendelton, 1983]. He reported that patients mentioned these factors of communication almost 3 to 1 over "medical" factors in assessing their encounters with physicians. In an analogous American investigation, Pamela Willson and J. Regis McNamara found that the satisfaction of subjects observing simulated doctor-patient encounters was affected by 14 factors of perceived "courtesy" in communication [Willson & McNamara, 1982]. Canadian Moira Stewart has demonstrated that there are distinct correlations between high patient satisfaction and three factors: the doctor's solicitation of the patient's opinions, the patient's giving opinions, and the patient's expressing tension [Stewart, 1984].

While "courtesy" is not a moral term, it is clear that this work documents the ethical argument that physicians who encourage communication, and who treat their patients with the respect due autonomous persons, are more readily perceived to share their patients' interests than are doctors who maintain traditional philanthropic attitudes toward interaction. It also suggests that the converse is true, that ethical doctors provide care and communication which satisfies their patients' desire for respect as
persons, although nothing can be known about the physicians' ethical presuppositions. Most importantly, as the role that the doctor permits the patient to take appears to be as important for patient satisfaction as the physician's own skills in giving information, it is evident that the patients included in this substantial body of research prefer the active role of covenental partner to the passive role allotted them by the philanthropic model.

Additional research suggests that good communication may be more important in creating or sustaining the doctor-patient relationship than even the doctor's technical efforts at restoring the patient to health; it is not unusual for patients' evaluation of other aspects of medical care to be influenced by their appreciation of good communication. M. Robin DiMatteo and Ron Hays found that patients who thought that their doctors were good communicators not only considered them to be caring but technically expert as well [DiMatteo & Hays, 1980]. Moreover, F. Ross Woolley and his colleagues observed that patients' good will toward doctors who explained the causes of disease and the mechanism of recommended treatment overcame even "bad" medical outcomes [Woolley et al., 1978]. Surprisingly, this effect was noted even when the doctor made an effort to communicate the information but was unable to do so effectively. This important finding suggests that patients, too, accept the traditional presupposition that
medicine's true moral purpose is not simply to cure the sick, but to support them in their struggle against illness.

DiMatteo and Hays have also explained this phenomenon in terms of the typical patient's limited expertise in medicine: because most patients are strangers to the medical world, they cannot judge the quality of their doctors' technical skills while they can and do judge communication and affect [DiMatteo, 1979; DiMatteo & Hays, 1980]. Edward J. Speedling and David M. Rose, Zeev Ben-Sira, and Alexander Segall and Margaret Burnett have echoed this point, arguing that patients cannot always determine whether their doctors contribute to their physical improvement, but they do know whether their physicians give them reassurance and support [Ben-Sira, 1976; Segall & Burnett, 1980; Speedling & Rose, 1985]. Patients of lower socioeconomic status, strangers both to medicine and the social world of the physician, place particular emphasis on rapport and good communication with their doctors in evaluating their care [DiMatteo & Hays, 1980].

The role of poor communication between doctor and patient in undermining their relationship appears to be similarly important. Mindi Miller's work with malpractice plaintiffs indicates that their physicians' poor communication behavior contributed significantly to the claimants' decision to sue; their desire for information about the bad outcome of treatment was often a more
important reason for litigation than was the fact that a mishap had occurred [Miller, 1986]. The patients in Miller's study claimed a right to know about their care, and when they believed that the physician had withheld such information or had given them information that was not credible, they were angry, especially if they had asked specifically to be informed. Miller's findings are echoed by anthropologist Irwin Press, who notes that physicians must address patients' personal explanatory models for illness if they are to be perceived as giving information [Press, 1984].

While the work of DiMatteo and Hays, Ben-Sira, Segall and Burnett, and Speedling & Rose shows how open communication can build up a relationship between strangers, Miller's study illustrates how that relationship can be undermined by the physician's traditional assumption that patients' requests for information need not be met. Although the patients in Miller's study indicated that the lack of rapport with their doctors was not as important a factor in their dissatisfaction as was the fact that the physicians withheld crucial information, it seems evident that had their rapport been better -- had the physicians recognized and respected their patients' autonomy and need for information, their relationships would not have ended in litigation. Malpractice suits are a negative incentive for physicians to establish covenantal relationships with their
patients, but the positive moral lessons of such litigation should not be overlooked.

The Stranger in the Hospital -- Alone in a Silent World

It is not surprising that almost all of the patients in Miller's investigation had been hospitalized when the alleged malpractice against them occurred. It is not simply that a greater chance for error or unexpected outcome exists with the more difficult procedures performed in the hospital. The hospital is a world in which the typical patient is a stranger in many ways, and while the hospital patient's need for good communication is likely to be much greater than that of clinic or office patients, meeting that need may also be more difficult in the hospital, as many factors create an atmosphere where silence is the norm.

Barriers to communication with the captive patient

The individual who becomes a hospital patient is often not only a stranger to the physician, but also to a host of nurses and other personnel, as well as to the institution itself. Whereas in a primary care setting the patient is stranger passing through, soon to return to the security of his or her own world, the hospital patient is subsumed by the institution and its unfamiliar rules and routines for an extended period. Even experienced primary-care patients may be completely unfamiliar with the highly bureaucratic hospital, and disconcerted by the hospital's emphasis on
technology never used in the doctor's office. Albert Jonsen and Andre Hellegers have described the typical person entering the hospital as nervous, afraid, or even terrified as they face the mysterious domain of powerful healers with specialized knowledge and magical skills [Jonsen & Hellegers, 1974].

In the unfamiliar surroundings of the hospital, patients are typically quite dependent upon the strangers who care for them. The patients' ailments contribute to this dependency, as their conditions are often serious enough to cause an even greater loss of control than usually accompanies illness. However, the hospital as an institution is designed to facilitate the smooth operation of its many separate services, and their standardization is often achieved through structures and practices which intentionally place the patient in a passive, dependent role. Sociologist Erving Goffman has described the incorporation of persons into institutions such as the hospital as the "stripping process" in which the individual is stripped of all personal identity, autonomy, and separate status through rituals and procedures which focus on the needs of the institution as a whole [Goffmann, 1961].

Sociologists Hans Mauksch, and Raymond S. Duff and August B. Hollingshead have identified a number of common hospital practices which contribute to the "stripping" of the individual patient [Duff & Hollingshead, 1968; Mauksch,
1975]. The wait at the admission desk is an expression of the power of the institution over the patient, and the identification bracelet placed on the patient's wrist at the time of admission is a statement of possession similar to a brand. Once in his or her room, the patient must remove street clothes and wear a hospital gown or pajamas, regardless of the time of day or reason for hospitalization. This dress contributes to the patient's acceptance of the sick role and significantly adds to a feeling of powerlessness before the powerful, uniformed staff.

The patient is also required to give up behaviors and personal belongings that help to maintain identity and autonomy: in some cases even glasses and false teeth must be surrendered. Such simple items as a cup of coffee or a box of tissues must be requested from the staff. Meals are served according to a schedule that may not coincide with the patient's own habits and may include foods that the patient would not choose; sleeping schedules are determined by nursing shifts. A patient who is personally responsible for taking medications at home must relinquish that responsibility -- and any feeling of control over the disease -- to nurses. Because many hospitals place restrictions on patients' movements within the hospital, patients are often confined to their rooms to wait passively for staff and visitors, and some even may be completely separated from their families.
On rare occasions new patients may receive specific orientation to the hospital, but this instruction may be the exception rather than the rule [Duff & Hollingshead, 1968; Mauksch, 1975; Tagliacozzo & Mauksch, 1979]. This omission is due not simply to the staff's busy schedules, but more often to the patient's lack of status in the hospital. Alfred Schutz's psychological description of the stranger suggests that, because of his or her lack of status in the new group or environment, the stranger is seldom able to understand its cultural pattern [Schutz, 1961]. Thus the meaning of everything is in question, and the newcomer attempts to interpret the most minute details of the strange new world in terms of familiar patterns.

This general ignorance and insecurity about the hospital is compounded for most patients by the fact that their private or semiprivate rooms isolate them from other patients. The lack of informal interaction with peers who can assist in interpreting the system also serves to diminish the power of the individual patient before the institution. Isolation from others makes the patient highly dependent upon contact with hospital staff, and even more unlikely to assert the autonomy which might jeopardize good relations with them. Like a stranger in any new setting, the newly hospitalized person seeks to determine the rules of the system, and the behavior expected of patients, through informal communication which does not challenge the
staff's authority.

Because the patient sees the staff members as figures of power, their every action is interpreted, rightly or wrongly, as reward or punishment given in response to patient behavior [Mauksch, 1975]. Most patients believe that it is extremely important to meet the staff's expectations -- to be a "good patient", and they tailor their demands on the staff to maximize perceived rewards and minimize perceived punishment. Thus the importance of the patient's communication with staff members goes beyond the simple meaning of the spoken words: patients believe that the decision to ask a question, make a request, or voice an opinion always carries the risk of annoying or offending the staff member in question. Patients choose their words, and weigh their reasons for speaking, very carefully [Mauksch, 1975].

Mauksch and fellow sociologist Daisy L. Tagliacozzo have argued that the hospital patient is not a fully autonomous person, but a "captive" incapable of playing the role of "consumer" for fear of criticism and rejection from those to whom he or she turns for help [Tagliacozzo & Mauksch, 1979]. Because patients typically envision the hospital as a system that handles human crises, many also feel bound by moral commitments to other patients, real or imagined, with greater needs; often they refrain from asserting their own self-interests out of fear that doing so
might compromise another's care and bring criticism from the rest of the hospital community. Moreover, Mauksch and Tagliacozzo have found that many patients also recognize a moral commitment to their "busy" doctors and nurses not to cause problems and to get well as soon as possible.

These conclusions demonstrate clearly that the comprehensive communication endorsed by many in health care as the foundation of patient-caregiver interaction must be initiated and maintained by caregivers, whether physicians, nurses, or others. As strangers to the system, patients will not take the necessary steps to obtain the information and reassurance crucial to their full recovery because the system itself undermines their sense of autonomy and ability to ask questions. If the patient's rights as an autonomous partner in the therapeutic relationship are to be maintained, the caregiver must protect them by providing the patient a realistic opportunity to negotiate and supplying enough information on which to make true choices. As Engelhardt has insisted, the patient who is the greatest stranger to the hospital has the greatest need for such opportunity and encouragement from all of his or her caregivers.

In many hospitals across the country, however, there are patients who pose an enormous challenge to this commitment to good communication and negotiation of relationships, patients who are strangers not only to the
world of hospital medicine and the dominant culture, but
strangers as well to the language in which their caregivers
seek to treat them. Patients who speak no English are
strangers *par excellence* in American health care; their
substantial need for information to overcome often vast
differences in moral and cultural values, models of health,
ilness, and appropriate patient behavior, and expectations
of care are compounded by the difference in language that
often makes it completely impossible for them to express
these needs. Little factual information from the staff
filters through the language barrier, and even caregivers
dedicated to preserving patient autonomy may find themselves
engaging in paternalism when they are unable to speak the
patient's language.

Non-English speaking patients (NESPs) are an excellent
worst-case example of the vital connections between ethical
health care and good communication between patients and
caregivers: competent adults are denied the information and
freedom to choose essential to informed consent because
thorough communication is difficult or impossible. But the
treatment of NESPs is more than just an interesting ethical
case study, it is a very real problem for the millions of
people in this country who speak no English and the many
more who provide their health care. Nonetheless, theirs is
a situation which has been overlooked in the vast literature
of medical ethics, despite concern for other populations
subject to coercion and paternalism.

The non-English speaking patient in the American hospital

The number of people whose inability to speak English affects their interaction with the American health care system is unknown and difficult to estimate. The most recent figures from the United States Census Bureau indicate that 4,133,484 persons, almost 2% of the population, speak English poorly or not at all [U.S. DCBC, 1982]. This figure is believed to be much lower than the actual number due to significant underreporting. The census is conducted largely by mail, and it is likely that no information was returned from households where no one speaks English. Moreover, it is estimated that while the census counted approximately 2 million undocumented aliens, the actual number approaches 6 million, many of whom have no permanent address and thus often evade census takers [U.S. Senate, 1985]. Although some of these persons may speak English, it is quite likely that the majority do not.

In 1985, a private study of Hispanics in the United States found that only 43% of Hispanic Americans report that they speak English "well" or "very well" [Anonymous, 1986]. Of the total 18.8 million Hispanics in the U.S. in 1987, therefore, roughly 10.7 million may have some difficulty communicating in English. This figure, again, is based upon unreliable census estimates of undocumented aliens and the real total may be significantly larger.
A study by public health physician Harry D. Karpeles and his colleague Roslyn Gorin in the late 1970s and early 1980s found that 13% of the patients in 12 of the largest hospitals in Philadelphia were unable to speak or understand English well enough to establish basic communication with their caregivers [Anonymous, 1984; Karpeles & Gorin, 1983]. They estimated that in 1976 over 300,000 patient contacts in Philadelphia's acute care facilities were affected by a language barrier, and comparable data for 1980 and 1981 indicated similar figures.

In cities well known for their specialized medical services, the NESF population may extend beyond the local residents, as citizens of other countries seeking American technological expertise also turn to the American hospital. In Houston, the foreign patient population is extremely large: the Texas Medical Center reports that in 1986 roughly 25,000 persons from foreign countries were treated in the Center's many institutions, usually as inpatients [Hickmann, 1987]. Most had come from Latin America, although significant numbers came from the Middle East and Europe. These figures are up over 300% from 1982, despite the precipitous decline in the Latin American economy in the interim [TMC, 1983].

Whatever the precise numbers now, the non-English speaking population in America is growing, and with it the population of NESFs. The Bureau of the Census noted a 30%
increase in the Hispanic population between 1980 and 1987 [Anonymous, 1987; U.S. DCBC, 1987]. A huge increase in immigration from Mexico and Central American, a quarter of which is illegal, has accompanied the economic decline in the Latin American oil industry and growing civil strife. Largely as a result of this immigration, the Hispanic population in Houston, the seventh largest in the country, is projected to become the city's largest ethnic group by the end of the century [Anonymous, 1986; Bennett, 1986]. The Asian population in Houston and nationwide is undergoing similar growth from immigration [Olafson, Cantwell, & Lim, 1986]. The conclusions of Karpeles and Gorin's work in Philadelphia suggest that the adults among these immigrants are unlikely to achieve sufficient proficiency in English to communicate adequately with hospital personnel, and as they develop medical problems with age, the health care system will be faced with an increasing number of NESP{\textsuperscript}s [Karpeles & Gorin, 1983].

While concentrated near the United States' border with Mexico, along coastlines, and in cities with established immigrant communities, the growing immigrant population is making an impact on health care systems across the country [Abrahams, 1988; Anonymous, 1983; 1984a; 1984b; Bullough & Bullough, 1982; Candib, 1983; Crowther, 1975; DeVore & Koskela, 1980; Fitzgerald, 1988; Himmelstein et al., 1983; Kohut, 1975; Morgan, 1983; Wright, 1981]. Not surprisingly,
caring for patients who speak another language is also a problem for health care professionals in other industrialized countries with large immigrant populations from former colonies or indigenous groups who use only their native languages [Bal, 1981; Nash, 1979; Stockwell, 1972; Websdale, 1982; Wright, 1983; Zimmermann, Riedesser, & Schindera, 1982].

How hospitals will cope with the rising numbers of NESPs is unclear. Researchers who have examined the situation of NESPs in the past have demonstrated that their care is often seriously compromised by the language barrier. Inability to speak English has been shown repeatedly to be a significant deterrent to NESPs' seeking health care, and such delays are recognized to have serious consequences for the patient's health [Bullough & Bullough, 1982; Li et al., 1983; Rodriguez, 1983; Trevino & Moss, 1984; Weaver, 1973]. When NESPs do turn to the hospital for help, their difficulty in communicating with caregivers sometimes results in incorrect diagnoses and avoidable errors in treatment [Bullough & Bullough, 1982; Candib, 1983; Himmelstein et al., 1983; Zimmermann, Riedesser, & Schindera, 1982]. On other occasions NESPs have been denied the regular services of certain caregivers or departments because of their inability to speak English [Crowther, 1975; Delano, Lundin, & Friedman, 1982; DeVore & Koskela, 1980; Stockwell, 1972]. Recently, it has been noted that a
significant percentage of patients who undergo court-ordered treatment are less than proficient in English [Kolder, Gallagher, & Parsons, 1987].

How NESP's can be accommodated by the hospital, treated with respect by the many professionals who will care for them, and allowed the active role that contemporary ethics gives to all patients ultimately is reduced to the question of how communication with NESP's can be achieved. To date the provisions made by hospitals have been few and uneven, despite an official statement in 1975 from the Joint Commission of the Accreditation of Hospitals that patients who do not speak or understand the predominant language of the community should have access to an interpreter, especially in a setting where such language barriers are an ongoing problem [JCAH, 1976]. Yet how hospitals can meet NESP's needs, and help staff members fulfill their ethical duties to NESP's as autonomous persons, is a question that is not answered even in the JCAH statement.

Houston's NESP's and their hospital experiences -- a study

The goal of providing ethical health care for NESP's can be met only if their current situation is understood and its considerable problems exposed. It is essential to determine how NESP's are treated in the American hospital, how they perceive the language barrier to affect their care, and how they assess the care that they receive. It must also be determined whether and how NESP's' needs are different from
those of English-speaking patients (ESPs), and how NESP
define what they want in hospital care. Equally important
is the perspective of the caregiver on how NESP are
different from other patients; how the language barrier
affects the caregiver's abilities; what works in caring for
NESP, and what does not; and what special skills or
services caregivers find essential to working with NESP.
To answer these questions, and to discover as much as
possible about the hospital experience of NESP in Houston,
I carried out a month-long research project in one of the
city's largest teaching hospitals.

This investigation had three components, each of which
had several goals. In the first, a series of patient
interviews, 1) the characteristics of the study's Hispanic
NESP population were identified, and 2) the quality of the
communication between NESP and staff members was assessed
in comparison to the communication between ESP and hospital
personnel. In the second, staff members were interviewed
about 1) their experiences with caring for NESP in general,
and 2) their work with the study's patients in particular;
these latter responses were compared to those of the
patients to determine the similarity of their perceptions.
In the third, patients' medical records were examined to
determined whether and when staff members used interpreters
to communicate with their NESP, and to ascertain whether
there was any difference between NESP and ESP in terms of
their lengths of hospitalization.

It is important to note that while the standards of social science research were adhered to as much as possible in this effort, and although the study's results are presented in formal charts and statistical breakdowns, this research is not intended as a definitive statement on NESPs or their caregivers. Rather, it is an exploration of a very complex problem, focusing on the experiences of a small group of patients. Although its conclusions might have application to formal policy, it is intended primarily to inform a discussion of ethics. The results of this investigation and the ethical analysis of its implications make up the following five chapters.

Notes to Chapter 1

1. Probably the most offensive example of the term "management" used as a synonym for care or treatment comes from pediatricians Raymond S. Duff and A.G.M. Cambell, who use it in a discussion of the treatment severely deformed newborns in the neonatal intensive care unit. Among their recommendations for treating such infants, they suggest that doctors consider early death as a "management option" [Duff & Campbell, 1973].

2. I am unwilling to accept the assumption behind this movement that the word patient intrinsically implies dependency and lack of autonomy. It is the way in which the word is used that has given it that meaning. The word "client" could easily assume the same negative attributes which "patient" has taken on if the attitudes of those using the word do not change as well.

3. Whereas the contractual relationship defined by Engelhardt assumes that the physician or other caregiver
may refuse to fulfill certain aspects of what the patient believes to be needed, if he or she spells out such limitations in advance, there is no such concept in the advocacy model of nursing.

4. What little dialogue has taken place between physicians and nurses about their respective commitments to patients has focused on doctors' perception that nurses envision themselves to be the sole advocates for the patient, often against the physician. The physicians' response has not been favorable [Berger, 1987; Theis, 1986].

5. To simplify discussion, the authors of this study refer to the mothers of the children actually receiving treatment as the "patients".

6. The patient population was sufficiently small, in fact, that the vast majority of the study's results were not statistically significant. Except where a significant p-value is stated explicitly, it should be assumed that the figures are not statistically significant.
Chapter 2

Introduction to the Hospital Study

The hospital chosen as the site for this study is a large, urban teaching hospital with a varied patient population. It was selected because of its Spanish interpreter service and policy of providing translation for NESPs, its acceptance of Medicare, Medicaid, and nonresource patients in addition to those with private insurance, and its use by foreign patients seeking specialized treatments. Moreover, the diversity of its services and its active emergency room promised a broad spectrum of patients and diagnoses.

Study Design

The study was carried out in October, a month in which admissions are affected neither by the rise in accidental trauma, acts of aggression, and childbirth that normally occurs during the summer and holidays, nor the tax- and insurance-motivated increase in elective procedures that comes at the end of the year. In addition, by October, residents and medical students, whose tenure begins on July 1, have become familiar with hospital routine and the demands of caring for patients.

Because this investigation focused specifically on the role of communication in hospital care, it was necessary to narrow its non-English speaking population as much as
possible to limit the effect of differences in language, cultural and socioeconomic background, and familiarity with American hospitals on the patients' understanding of their care. The population studied was limited to Hispanics, as Spanish is the most commonly spoken language among non-English speaking persons both in Houston and across the United States.¹ In addition, in the portions of the study relating immediately to communication, each non-English speaking Hispanic subject was matched to an English-speaking Hispanic control as similar as possible in diagnosis and socioeconomic background according to 5 criteria.

Subjects and controls were recruited from the hospital's adult, Hispanic inpatients admitted during the month of October 1985 for stays of more than 48 hours. Their names were obtained from the daily admission "face sheets" that include information on race or ethnic group. In each case, the attending physician was contacted first for permission to visit the patient. Patients admitted to psychiatric or intensive care units and those listed as "no information" were not contacted. Those physically unable to communicate or incapable of giving informed consent did not qualify for the study; however, patients whose improvement qualified them for participation were recruited as they became eligible.

Patients were solicited for the study largely in the order of their admission. In some cases this order had to
be modified when certain patients were unavailable or their doctors' approval could not be obtained. The patients contacted for the survey were given general information about the project, then invited to participate. Patients who agreed to take part received a comprehensive explanation of the study's nature and purpose, and were asked to sign an informed consent document approved by the Rice University Institutional Review Board for the Protection of Human Subjects from Research Risks and the hospital's institutional review board [See Appendix I for consent forms]. Copies of the consent form were available in both English and Spanish, and all patients were offered an oral reading of the form in the language of their choice before signing it.

Patients' ability to speak English was determined from their participation in the discussion that took place during the consent process. Patients whose native language was English or who made few errors ("Native/near native"), and those whose comprehension and speech was good, despite problems with grammar or vocabulary ("Good"), were classified as ESPs. Patients who did not understand even the simplest English ("None at all), or who knew only a few words and were unable to understand or speak in full sentences in English ("Poor"), were classified as NESP$. All NESP$. were interviewed in Spanish by the investigator.

Insofar as was possible, patients were contacted on the
third or fourth day after admission. While interviewing later in their stay might have meant a greater range of experiences for some patients, the short hospitalization time of many others would have resulted in the loss of a significant number of potential subjects. Moreover, it has been demonstrated that after only a few days many hospital patients adopt what they believe to be an appropriately passive role, and are thus less likely to evaluate their experiences objectively or report complaints [Goffman, 1961; Mauksch, 1975]. The minimum length of stay required for eligibility was 48 hours, giving patients the opportunity to have a number of contacts with a variety of staff members, and to begin tests or treatment before being interviewed.

The core of this study was a twenty-minute interview consisting of a structured series of fixed-alternative and open-ended questions. The interview focused on questions about the frequency and quality of communication with caregivers, patients' knowledge of their diagnoses and treatment, and their satisfaction with care. Basic demographic information, including the patient's nationality, level of education, work status, and income, was also obtained in order to describe the hospital's Hispanic population and to assign subject-control matches [See Appendix II for the text of the questionnaire in both English and Spanish].

After each patient was interviewed, a brief survey was
also conducted with his or her primary caregivers. The staff surveys used similar fixed-alternative and open-ended questions in order to compare staff and patient perceptions of care. For each patient interviewed, the attending physician or a housestaff physician, a member of the nursing staff, and personnel such as physical therapists or social workers (where applicable) were contacted. Staff members' names were obtained as part of the patient interview when possible, or from patients' chart. In all but one instance, at least two practitioner interviews were conducted for each patient in the matched population. The comparisons between patients and staff responses are given for the matched population only [See Appendix III for the text of the staff questionnaire].

The staff members were also surveyed about their general experiences in caring for NESPs. Their perceptions of the treatment given to NESPs by others, and of their own abilities to care for NESPs, were solicited. Staff members were asked to offer suggestions for improving NESP care and making the job of working with NESPs less difficult for personnel who speak only English. The responses of all of the staff members interviewed are reported.

The final phase of the investigation was a post-discharge chart review for each of the adult Hispanic patients, both NESPs and ESPs, admitted during October. The charts of patients who had not been contacted for the
interview were examined in order to complete demographic information often missing from the admission face sheets and to categorize them as NESPs or ESPs. The staff notes and consent forms of NESPs' charts were checked for the staff's recognition of the patients' inability to speak English and use of translation to communicate with their NESPs. Each patient's medical record was also reviewed for length of hospitalization and Diagnosis Related Group (DRG) category. Where this information was not available in the patient's medical record, it was taken from the more complete hospital computer file.

**Characteristics of the Hospital's Hispanic Population**

During the month of October 1985, 226 Hispanic adults were admitted to the study hospital as inpatients. Two hundred twenty-seven patients were officially listed as "Spanish", although one was actually Russian and one was Filipino. One patient listed as "White" was a non-English speaking Mexican-American, making a total of 226 Hispanic patients. Of these 226, 160 were English-speaking, while 66 spoke little or no English [See Table 1 for a breakdown of the total population by language, gender, age, admission type, service, and insurance coverage].

Women were much more heavily represented than men, due in part to the hospital's busy obstetrics service. Of the total Hispanic population, almost two-thirds of the patients were women. This proportion was roughly the same among the
### Table 1. Profile of total Hispanic population

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total N=226</th>
<th>NESPs N=66</th>
<th>ESPs N=160</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>142 (63%)</td>
<td>32 (48%)</td>
<td>110 (69%)</td>
</tr>
<tr>
<td>Male</td>
<td>84 (37%)</td>
<td>34 (52%)</td>
<td>50 (31%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Total N=226</th>
<th>NESPs N=66</th>
<th>ESPs N=160</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>58 (26%)</td>
<td>13 (20%)</td>
<td>45 (28%)</td>
</tr>
<tr>
<td>25-34</td>
<td>88 (39%)</td>
<td>25 (38%)</td>
<td>63 (39%)</td>
</tr>
<tr>
<td>35-44</td>
<td>37 (16%)</td>
<td>9 (14%)</td>
<td>28 (18%)</td>
</tr>
<tr>
<td>45-54</td>
<td>10 (4%)</td>
<td>6 (9%)</td>
<td>4 (3%)</td>
</tr>
<tr>
<td>55-64</td>
<td>19 (8%)</td>
<td>4 (6%)</td>
<td>15 (9%)</td>
</tr>
<tr>
<td>65+</td>
<td>14 (6%)</td>
<td>9 (14%)</td>
<td>5 (3%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admitted via</th>
<th>Total N=226</th>
<th>NESPs N=66</th>
<th>ESPs N=160</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>72 (32%)</td>
<td>23 (35%)</td>
<td>49 (31%)</td>
</tr>
<tr>
<td>Emergency room</td>
<td>78 (35%)</td>
<td>28 (42%)</td>
<td>50 (31%)</td>
</tr>
<tr>
<td>Labor &amp; delivery</td>
<td>76 (34%)</td>
<td>15 (23%)</td>
<td>61 (38%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Total N=226</th>
<th>NESPs N=66</th>
<th>ESPs N=160</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>98 (43%)</td>
<td>37 (56%)</td>
<td>61 (38%)</td>
</tr>
<tr>
<td>Medicine</td>
<td>34 (15%)</td>
<td>11 (17%)</td>
<td>23 (14%)</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>88 (39%)</td>
<td>17 (26%)</td>
<td>71 (44%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Total N=226</th>
<th>NESPs N=66</th>
<th>ESPs N=160</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>153 (68%)</td>
<td>38 (58%)</td>
<td>115 (72%)</td>
</tr>
<tr>
<td>Medicare/Medicaid</td>
<td>36 (16%)</td>
<td>9 (14%)</td>
<td>27 (17%)</td>
</tr>
<tr>
<td>No insurance</td>
<td>37 (16%)</td>
<td>19 (29%)</td>
<td>18 (11%)</td>
</tr>
</tbody>
</table>
ESP's, although the percentages of men and women among the NESP's were more nearly equal.

The largest group of patients by age among the total Hispanic population and in both of the language subgroups consisted of patients between 25 and 34 years old. The 18-24 year old group was the second largest in the total population, paralleled by both ESP's and NESP's. These figures are in keeping with census and market research data which show that the significant portion of the Mexican-American population in the U.S. and in Houston falls in the 18-35 year old category [Anonymous, 1986b; U.S. Dept. Commerce, 1982]. This group was followed by the 35-44 year olds. Of the total population and the ESP's, the 45-54 age group was the smallest, while the 55-64 age group was the smallest among the NESP's.

Total Hispanic admissions were divided almost evenly among the Emergency Room, Labor and Delivery, and Admissions desk. Figures for ESP’s were similar, while among NESP’s the percentage of admissions to Labor and Delivery was lower and to the Emergency Room higher. Among the patients admitted through the ER, almost half were the victims of a motor vehicle accident, act of aggression, or work-related accident. Twice as many NESP’s as ESP’s admitted through the ER were victims of trauma.

In the Hispanic population as a whole and in both of the subgroups, admissions to obstetrics and surgical
services, particularly trauma, were the most common. Surgery was the most common service for NESP admissions and obstetrics was the most frequent among ESPs. Admissions to medicine services and psychiatry were less frequent in the total population and the subgroups as well.

Slightly more than two-thirds of the total Hispanic population was covered by some form of private health insurance. Almost three-quarters of the ESPs had private insurance, but only slightly more than half of the NESP were covered privately. These figures are consistent with federal data on insurance coverage for Hispanics nationwide [Treviño & Moss, 1984]. Medicare or Medicaid patients accounted for approximately 15% of the total Hispanic population, as well as the ESPs and NESP separately. The remainder were self-paying and nonresource patients. More than twice the percentage of NESP fell into this category as ESPs; most of the uninsured NESP were victims of trauma admitted through the ER.

The subject sample constituted roughly one third of the total Hispanic population of both the NESP and ESP groups. Within the 5 demographic categories the percentage breakdowns for the subject sample are also roughly equivalent to those of the larger population [See Table 2 for a breakdown of the demographic information on gender, age, admission type, service, and insurance for the NESP and ESP samples]. Existing variations are due to smaller
<table>
<thead>
<tr>
<th></th>
<th>Total N=77</th>
<th>NESP N=25</th>
<th>ESP N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>51 (66%)</td>
<td>16 (64%)</td>
<td>35 (67%)</td>
</tr>
<tr>
<td>Male</td>
<td>26 (34%)</td>
<td>9 (36%)</td>
<td>17 (33%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>17 (22%)</td>
<td>4 (16%)</td>
<td>13 (25%)</td>
</tr>
<tr>
<td>25-34</td>
<td>25 (32%)</td>
<td>8 (32%)</td>
<td>17 (33%)</td>
</tr>
<tr>
<td>35-44</td>
<td>15 (19%)</td>
<td>2 (8%)</td>
<td>13 (25%)</td>
</tr>
<tr>
<td>45-54</td>
<td>6 (8%)</td>
<td>4 (16%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>55-64</td>
<td>8 (10%)</td>
<td>2 (8%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>65+</td>
<td>6 (8%)</td>
<td>5 (20%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td><strong>Admitted via</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>32 (40%)</td>
<td>10 (40%)</td>
<td>21 (40%)</td>
</tr>
<tr>
<td>Emergency room</td>
<td>26 (34%)</td>
<td>9 (36%)</td>
<td>17 (33%)</td>
</tr>
<tr>
<td>Labor &amp; delivery</td>
<td>20 (26%)</td>
<td>6 (24%)</td>
<td>14 (27%)</td>
</tr>
<tr>
<td><strong>Service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>36 (47%)</td>
<td>11 (44%)</td>
<td>25 (48%)</td>
</tr>
<tr>
<td>Medicine</td>
<td>16 (21%)</td>
<td>7 (28%)</td>
<td>9 (17%)</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>25 (32%)</td>
<td>7 (28%)</td>
<td>18 (35%)</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>46 (64%)</td>
<td>10 (40%)</td>
<td>36 (69%)</td>
</tr>
<tr>
<td>Medicare/Medicaid</td>
<td>15 (19%)</td>
<td>6 (24%)</td>
<td>9 (17%)</td>
</tr>
<tr>
<td>No insurance</td>
<td>13 (17%)</td>
<td>6 (24%)</td>
<td>7 (13%)</td>
</tr>
</tbody>
</table>
numbers of eligible English-speaking obstetric patients, many of whom were discharged in under 48 hours, and male, non-English speaking trauma patients, who either died from their injuries or were not sufficiently recovered during the course of the investigation to be interviewed. Both of these groups were large enough, however, to be represented adequately in the study.

Demographics of the study sample

The study sample consisted almost exclusively of members of the Houston community: all but a few of the total group lived in the greater Houston metropolitan area or within a 100 mile radius of the city [See Table 3]. Among the NESP's this figure was somewhat smaller; among the ESP's it was slightly larger. Only a few persons lived in other parts of Texas or came from countries outside of the United States. Two of these foreign residents came to Houston specifically to receive medical care at the study hospital; two were undocumented aliens who had been victims of an automobile accident a few days after arriving in this country.

Although the great majority of the subjects were residents of Houston, a considerable number were not American citizens [See Table 4]. Only a few of the NESP subjects held American citizenship; almost two-thirds were Mexican citizens despite their local residence. Another 2 of the NESP's were Cuban citizens, and 5 were citizens of
Table 3. Residence

<table>
<thead>
<tr>
<th></th>
<th>Total N=77</th>
<th>NESP N=25</th>
<th>ESPS N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston area</td>
<td>64 (83%)</td>
<td>18 (72%)</td>
<td>46 (88%)</td>
</tr>
<tr>
<td>100 mile radius</td>
<td>5 (6%)</td>
<td>2 (8%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Other Texas</td>
<td>3 (1%)</td>
<td>2 (8%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Other U.S.</td>
<td>1 (1%)</td>
<td>--</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Latin America⁴ - combined</td>
<td>4 (5%)</td>
<td>3 (12%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

other Latin American countries. Almost all of the ESP subjects were citizens of the United States. Only 5 of the ESPs were Mexican nationals.⁵

Table 4. Citizenship

<table>
<thead>
<tr>
<th></th>
<th>Total N=77</th>
<th>NESP N=25</th>
<th>ESPS N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>50 (65%)</td>
<td>3 (12%)</td>
<td>47 (90%)</td>
</tr>
<tr>
<td>Mexico</td>
<td>18 (23%)</td>
<td>15 (60%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Cuba</td>
<td>2 (3%)</td>
<td>2 (8%)</td>
<td>--</td>
</tr>
<tr>
<td>Central America</td>
<td>3 (4%)</td>
<td>2 (8%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>- combined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South America</td>
<td>4 (5%)</td>
<td>3 (12%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>- combined</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The employment status of the NESP and ESP subjects differed considerably between the two groups, particularly among the women [See Table 5]. Only a quarter of the NESP subjects were employed either full- or part-time, while more
than half of the ESPs had full-time jobs. Slightly more than two-thirds of the female NESPs responded that they "kept house", compared with only one-fifth of the female ESPs. These figures reflect the fact that most of the English-speaking obstetric patients held full-time jobs, while most of their non-English speaking counterparts did not work outside of the home. More NESPs than ESPs claimed to be retired, while a larger percentage of ESPs than NESPs were disabled.

Table 5. Employment status

<table>
<thead>
<tr>
<th></th>
<th>Total N=77</th>
<th>NESPs N=25</th>
<th>ESPs N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work full-time</td>
<td>30 (39%)</td>
<td>4 (16%)</td>
<td>26 (50%)</td>
</tr>
<tr>
<td>Work part-time</td>
<td>7 (9%)</td>
<td>3 (12%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7 (9%)</td>
<td>2 (8%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Keep house</td>
<td>18 (23%)</td>
<td>11 (44%)</td>
<td>7 (13%)</td>
</tr>
<tr>
<td>Attend school</td>
<td>2 (3%)</td>
<td>--</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Retired</td>
<td>6 (8%)</td>
<td>4 (16%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Disabled</td>
<td>7 (9%)</td>
<td>1 (4%)</td>
<td>6 (12%)</td>
</tr>
</tbody>
</table>

There were also some important differences between the NESPs and ESPs in terms of education level [See Table 6]. National census data for 1985 shows that 14% of adult Hispanics had completed fewer than five years of school, and that only 48% had completed high school [U.S. DCBC, 1985]. In contrast, over half of the NESP group had only an
elementary school education, and in many cases no formal schooling at all, compared with only 10% of the ESPs. Among the NESP only a few had finished high school, whereas half of the ESPs had high school diplomas and several had gone on to college.

Table 6. Educational level (last year of school completed)

<table>
<thead>
<tr>
<th></th>
<th>Total N=77</th>
<th>NESP N=25</th>
<th>ESP N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 3rd grade</td>
<td>8 (10%)</td>
<td>7 (28%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>4th - 6th grade</td>
<td>12 (16%)</td>
<td>8 (32%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>7th - 9th grade</td>
<td>13 (17%)</td>
<td>3 (12%)</td>
<td>10 (19%)</td>
</tr>
<tr>
<td>10th - 11th grade</td>
<td>13 (17%)</td>
<td>3 (12%)</td>
<td>10 (19%)</td>
</tr>
<tr>
<td>12th grade</td>
<td>20 (26%)</td>
<td>3 (12%)</td>
<td>17 (33%)</td>
</tr>
<tr>
<td>1 - 3 years college</td>
<td>8 (10%)</td>
<td>1 (4%)</td>
<td>7 (13%)</td>
</tr>
<tr>
<td>BA/BS degree</td>
<td>3 (4%)</td>
<td>--</td>
<td>3 (6%)</td>
</tr>
</tbody>
</table>

The impact that this extreme difference in education may have had on the two groups' interaction with the staff and their respective perceptions of care is considerable, and this discrepancy posed the greatest obstacle to assigning patient matches. However, the marked differences in patients' levels of education seemed to have only a limited impact on their total annual household income [See Table 7]. Moreover, neither the patient's citizenship nor employment status appeared to affect household income. These observations are consistent with a national study.
which found that English-speaking Hispanics do not necessarily surpass non-English speaking Hispanics in socioeconomic attainment [Veltman, 1980].

Table 7. Total annual household income in 1984

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Total N=77</th>
<th>NESPs N=25</th>
<th>ESPs N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$7,500</td>
<td>21 (27%)</td>
<td>8 (32%)</td>
<td>13 (25%)</td>
</tr>
<tr>
<td>$7,500 - 10,000</td>
<td>12 (16%)</td>
<td>3 (12%)</td>
<td>9 (17%)</td>
</tr>
<tr>
<td>$10,000 - 15,000</td>
<td>8 (10%)</td>
<td>3 (12%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>$15,000 - 20,000</td>
<td>12 (16%)</td>
<td>3 (12%)</td>
<td>7 (17%)</td>
</tr>
<tr>
<td>$20,000 - 25,000</td>
<td>7 (9%)</td>
<td>1 (4%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>$25,000 - 35,000</td>
<td>5 (6%)</td>
<td>--</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>$35,000 - 50,000</td>
<td>2 (3%)</td>
<td>1 (4%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>$50,000 - 75,000</td>
<td>1 (1%)</td>
<td>--</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>&gt;$75,000</td>
<td>1 (1%)</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
<tr>
<td>Don't know</td>
<td>8 (10%)</td>
<td>5 (20%)</td>
<td>3 (6%)</td>
</tr>
</tbody>
</table>

In both groups, slightly fewer than half of the patients reported household incomes under $10,000 a year -- below the 1985 federal poverty level of $10,650 [U.S. Senate, 1985], compared to 24% of the national Hispanic population [U.S. DCCB, 1985]; roughly the same percentage of each group had annual household incomes of under $7,500. In both groups approximately a quarter of the patients reported that they had had annual household incomes of between $10,000 and $20,000. However, 5 NESPs, all of whom were
nonworking obstetric patients, were unable to answer the question about household income. Because these women represent 20% of the NESP population, the actual income breakdown for that group could be somewhat different.

Figures on insurance coverage, related to both income and employment, indicate that NESPs may be less likely than ESPs to hold jobs which provide insurance benefits, although such conclusions are tentative as many patients were covered under a spouse's policy [See Table 2]. Although there is no difference in the proportions of NESPs and ESPs covered by Medicare and Medicaid, the types of coverage were different between them. All but one of the NESPs with government-funded insurance were retired persons on Medicare, whereas several of the ESPs were indigent mothers whose obstetric care was covered by Medicaid, and all but one of the rest were covered by Medicare because of disability.

Perhaps related to their lack of insurance coverage [Treviño & Moss, 1984a; 1984b], NESPs were less likely than ESPs to have been hospitalized previously, although the majority of both groups had been admitted at least once before. Seventy-two percent of the NESPs had prior experience with hospitalization, compared to 87% of the ESPs [See Table 8]. However, a few NESPs had been treated only in hospitals outside of the United States, so that just over half of the NESP group had personal experience with American hospitals.
Table 8. Hospitalized previously

<table>
<thead>
<tr>
<th></th>
<th>Total N=77</th>
<th>NESP N=25</th>
<th>ESP N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>64 (83%)</td>
<td>18 (72%)</td>
<td>46 (88%)</td>
</tr>
<tr>
<td>No</td>
<td>13 (17%)</td>
<td>7 (28%)</td>
<td>6 (12%)</td>
</tr>
</tbody>
</table>

Of those patients who had been hospitalized before, many had been patients at the study hospital [See Table 9]. Roughly half of the NESP's hospitalized previously had been patients at the study hospital at least once before, as had half of the ESPs hospitalized previously.

Table 9. Hospitalized previously at study hospital

<table>
<thead>
<tr>
<th></th>
<th>Total N=64</th>
<th>NESP N=18</th>
<th>ESP N=46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31 (48%)</td>
<td>8 (44%)</td>
<td>23 (50%)</td>
</tr>
<tr>
<td>No</td>
<td>33 (52%)</td>
<td>10 (56%)</td>
<td>23 (50%)</td>
</tr>
</tbody>
</table>

Many of the patients had been hospitalized previously with a condition similar to the one for which they were being treated at the time of the study [See Table 10]. Two-thirds of the NESP's with a prior hospitalization had received inpatient care for a similar diagnosis, together with half of comparable ESPs. Of the total NESP and ESP samples, these figures represent 48% and 44% respectively. These percentages include most of the obstetric patients, as well as the patients with serious chronic illnesses.
### Table 10. Hospitalized previously with a similar condition

<table>
<thead>
<tr>
<th></th>
<th>Total N=64</th>
<th>NESP N=18</th>
<th>ESPS N=46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>35 (55%)</td>
<td>12 (67%)</td>
<td>23 (50%)</td>
</tr>
<tr>
<td>No</td>
<td>29 (45%)</td>
<td>6 (33%)</td>
<td>23 (50%)</td>
</tr>
</tbody>
</table>

Many of the NESP patients who had been hospitalized previously had been patients within the year prior to the admission in question [See Table 11]. Among those NESP patients with earlier admissions, almost half had been hospitalized during the previous year. Among those NESP patients previously admitted to the study hospital, three-fourths had been treated there within the preceding year, most for conditions similar to those under treatment at the time of the study. Most were obstetric patients. These totals represent a third and a quarter of the total NESP subject population.

### Table 11. Time since last hospitalization

<table>
<thead>
<tr>
<th></th>
<th>Total N=64</th>
<th>NESP N=18</th>
<th>ESPS N=46</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;6 months</td>
<td>14 (22%)</td>
<td>3 (17%)</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>6 - 12 months</td>
<td>9 (14%)</td>
<td>5 (28%)</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>8 (13%)</td>
<td>3 (17%)</td>
<td>5 (11%)</td>
</tr>
<tr>
<td>2 - 5 years</td>
<td>12 (19%)</td>
<td>2 (11%)</td>
<td>10 (22%)</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>14 (22%)</td>
<td>4 (22%)</td>
<td>10 (22%)</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>7 (11%)</td>
<td>1 (6%)</td>
<td>6 (13%)</td>
</tr>
</tbody>
</table>
ESPs who had been hospitalized previously were not as likely as were NESP\'s to have had a recent hospital admission. Although a third of the ESP\'s had been hospitalized within the previous 12 months, another third had not been inpatients in more than 5 years. Among those ESP\'s who had been treated at the study hospital on an earlier occasion, just over half had been hospitalized there within the year preceding their current admission. Most of these patients suffered from chronic diseases that required frequent inpatient treatment.

There were noticeable differences between NESP\'s and ESP\'s in the length of time that had elapsed between the onset of their medical problems and the time that they were hospitalized [See Table 12]. A third of the NESP\'s were hospitalized within 1 to 3 days of first experiencing trouble, compared to only 12% of the ESP\'s. Although some of these NESP\'s were trauma victims whose lives depended upon immediate hospital care, many were not. Roughly the same proportion of patients in both groups were hospitalized with chronic medical problems, but few in either group had let their problems go untreated for more than a year. Of the NESP\'s receiving treatment for chronic ailments of more than 12 months' duration, all had suffered from their conditions for 5 years or more. The same percentage of each group were obstetric patients who were hospitalized in labor for delivery.
Table 12. Time between onset of ailment and this admission

<table>
<thead>
<tr>
<th></th>
<th>Total N=77</th>
<th>NESP N=25</th>
<th>ESP N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 days</td>
<td>14 (18%)</td>
<td>8 (32%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>4 - 7 days</td>
<td>7 ( 9%)</td>
<td>--</td>
<td>7 (37%)</td>
</tr>
<tr>
<td>1 - 2 weeks</td>
<td>5 (10%)</td>
<td>1 ( 4%)</td>
<td>4 ( 8%)</td>
</tr>
<tr>
<td>2 - 4 weeks</td>
<td>5 (10%)</td>
<td>2 ( 8%)</td>
<td>3 ( 6%)</td>
</tr>
<tr>
<td>1 - 3 months</td>
<td>6 ( 8%)</td>
<td>2 ( 8%)</td>
<td>4 ( 8%)</td>
</tr>
<tr>
<td>3 - 6 months</td>
<td>4 ( 5%)</td>
<td>1 ( 4%)</td>
<td>3 ( 6%)</td>
</tr>
<tr>
<td>6 - 12 months</td>
<td>8 (10%)</td>
<td>2 ( 8%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>1 ( 1%)</td>
<td>--</td>
<td>1 ( 2%)</td>
</tr>
<tr>
<td>2 - 5 years</td>
<td>2 ( 3%)</td>
<td>--</td>
<td>2 ( 4%)</td>
</tr>
<tr>
<td>&gt;5 years</td>
<td>6 ( 8%)</td>
<td>3 (12%)</td>
<td>3 ( 6%)</td>
</tr>
<tr>
<td>Childbirth</td>
<td>19 (25%)</td>
<td>6 (24%)</td>
<td>13 (25%)</td>
</tr>
</tbody>
</table>

These figures also reflect that NESP were more likely than ESP to come directly to the hospital emergency room for treatment [See Table 2]. While 16% of the NESP and 13% of the ESP were taken to the emergency room having received no prior treatment other than first aid rendered by paramedics, an additional 4 of the NESP sought no care before turning to the hospital, as compared to only 3 of ESP [See Table 13]. ESP were much more likely than NESP to have consulted a family physician for treatment, although the two groups demonstrated a roughly equivalent tendency to seek care from a clinic or specialist first.
Patients in both groups were motivated to go to the hospital for largely the same reasons [See Table 14]. Physician referral was the primary reason given by a third of the NESP\(\text{s} \) and and a third of the ESP\(\text{s} \). However, 20\% of the NESP\(\text{s} \) and 29\% of the ESP\(\text{s} \) simply cited pain as the reason that they had sought hospital treatment. An additional quarter of the NESP\(\text{s} \) and 20\% of the ESP\(\text{s} \) went to the hospital in labor, and 16\% of the NESP\(\text{s} \) and 13\% of the ESP\(\text{s} \) were taken to the hospital by paramedics as the result of accidental trauma.
Table 14. Reason for going to the hospital

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total N=77</th>
<th>NESPs N=25</th>
<th>ESPs N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician referral</td>
<td>26 (34%)</td>
<td>8 (32%)</td>
<td>18 (34%)</td>
</tr>
<tr>
<td>Pain</td>
<td>20 (26%)</td>
<td>5 (20%)</td>
<td>15 (29%)</td>
</tr>
<tr>
<td>Labor</td>
<td>17 (10%)</td>
<td>6 (24%)</td>
<td>11 (21%)</td>
</tr>
<tr>
<td>Accident/trauma</td>
<td>11 (14%)</td>
<td>4 (16%)</td>
<td>7 (13%)</td>
</tr>
<tr>
<td>Recognized old symptoms</td>
<td>5 (6%)</td>
<td>2 (12%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Bleeding</td>
<td>3 (4%)</td>
<td>1 (4%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Other treatment</td>
<td>2 (3%)</td>
<td>1 (4%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (6%)</td>
<td>2 (8%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Multiple answers</td>
<td>9 (12%)</td>
<td>6 (24%)</td>
<td>3 (6%)</td>
</tr>
</tbody>
</table>

The subject-control matched population

To determine how the ability to communicate verbally with caregivers affected the patients' interpretations of their hospital experiences, it was necessary to isolate the factor of English-speaking ability from among the many variables which might affect that perception. While the influence of such factors can never be accounted for completely, an effort was made to reduce it as much as possible by matching every non-English speaking subject with an English-speaking control and examining the differences in their responses as a function of the ability to speak English.

After all of the patient interviews had been completed,
NESP subjects were matched with ESP controls based on 5 characteristics defined in the demographics portion of the interview: gender, diagnosis/service, age, level of education, and household income. Where identical diagnoses were not available, the service, part of the body affected, nature of treatment, and relative severity of the patient's condition were matched as closely as possible given the patients available. All NESP-ESP pairs matched for gender, and all but three pairs matched for diagnosis; most of the pairs matched well in at least four of the five categories.

Where matches could not be made in the categories of age, education, or income, the difference seldom exceeded one "level" of definition. Education was the most problematic of the categories because the NESP as a group differed so greatly from the ESPs in that area. However, even here in no case did the difference between subject and control exceed two "levels". Where more than one match could be made for a given NESP, other demographic factors, such as previous hospital experience, nationality, and work status were taken into account.

Twenty-three of the 25 NESP interviewed were paired with ESP controls. The two NESPs who were not paired were elderly, female Medicare patients on the medicine service who were being treated for serious chronic ailments. They were excluded in part because there were no similar patients among the ESPS, but also because their experiences were
quite unusual. One was being cared for by an attending physician, two residents, and a nurse who all spoke excellent Spanish, and had little trouble communicating with her caregivers. The other appeared to speak adequate English at times, but at night, whenever she was in pain, and shortly after her taking her pain medication, she spoke only Spanish and seemed able to understand only the simplest English words. Both women provide interesting insights into the subtleties of caring for NESPs, but were poor candidates for this study.

**Encounters Between Patients and Hospital Staff**

As a preliminary step in the patient communication survey, study participants were asked whether they had been visited or treated by hospital personnel from 12 patient-care professions at any time since their admission. The 12 staff positions listed were: attending physician, consulting specialist physician, resident physician, medical student, nurse, therapist (respiratory, physical, etc.), dietician, social worker, chaplain, patient representative, volunteer, and interpreter. Respondents were instructed to answer yes or no after each position was read.

Two major differences between NESPs and ESPs can be observed from the answers given by patients in the matched population [See Table 15]. The most important difference is that NESPs were much less able than ESPs to identify the roles of the staff members whom they saw, especially in the
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>DK</th>
<th>Yes</th>
<th>No</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Physician</td>
<td>13 (57%)</td>
<td>4 (17%)</td>
<td>6 (26%)</td>
<td>14 (61%)</td>
<td>5 (22%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Consulting Physician</td>
<td>6 (26%)</td>
<td>5 (22%)</td>
<td>12 (52%)</td>
<td>3 (13%)</td>
<td>16 (70%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Resident Physician</td>
<td>22 (96%)</td>
<td>1 (4%)</td>
<td>--</td>
<td>22 (96%)</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
<tr>
<td>Medical Student</td>
<td>3 (13%)</td>
<td>6 (26%)</td>
<td>14 (61%)</td>
<td>5 (22%)</td>
<td>3 (13%)</td>
<td>15 (65%)</td>
</tr>
<tr>
<td>Nurse</td>
<td>23 (100%)</td>
<td>--</td>
<td>--</td>
<td>23 (100%)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Therapist</td>
<td>2 (9%)</td>
<td>21 (91%)</td>
<td>--</td>
<td>3 (13%)</td>
<td>20 (87%)</td>
<td>--</td>
</tr>
<tr>
<td>Dietician</td>
<td>2 (9%)</td>
<td>21 (91%)</td>
<td>--</td>
<td>3 (13%)</td>
<td>20 (87%)</td>
<td>--</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1 (4%)</td>
<td>22 (96%)</td>
<td>--</td>
<td>1 (4%)</td>
<td>22 (96%)</td>
<td>--</td>
</tr>
<tr>
<td>Chaplain</td>
<td>4 (17%)</td>
<td>19 (83%)</td>
<td>--</td>
<td>10 (43%)</td>
<td>13 (57%)</td>
<td>--</td>
</tr>
<tr>
<td>Patient Representative</td>
<td>2 (9%)</td>
<td>21 (91%)</td>
<td>--</td>
<td>1 (4%)</td>
<td>22 (96%)</td>
<td>--</td>
</tr>
<tr>
<td>Volunteer</td>
<td>2 (9%)</td>
<td>21 (91%)</td>
<td>--</td>
<td>3 (13%)</td>
<td>20 (87%)</td>
<td>--</td>
</tr>
<tr>
<td>Interpreter</td>
<td>10 (43%)</td>
<td>13 (57%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
case of medical staff. Secondly, NESP's were less likely to be visited by ancillary personnel than were ESP's, and those who were seen by ancillary personnel frequently reported that the staff member said little or did not stay after discovering that the patient did not speak English.

Moreover, while the initial figures for the two groups appear to be quite similar, many of the NESP's responses proved to be incorrect when compared with charts notes made by their caregivers and comments that they themselves made later in the interview. The most frequent problem was that NESP's simply could not identify who came to see them, and they guessed at the staff members' roles based on gender or age, the tasks that they performed, or the subjects that they addressed. While the ESP's responses were also affected by this problem, they corresponded much more closely to other sources.

The patients' ability to identify caregivers refers only to their recognition of the practitioners' professional roles, not to their knowledge of staff members' names. Many patients could not name any of those who cared for them, not even their attending physician, whose name was printed on their hospital bracelet and door. The problem was more pronounced among NESP's, some of whom explained that while the staff members did introduce themselves, their names were "in English"; most of the staff whose names NESP's did know spoke Spanish and had Spanish-sounding names. ESP's were 2
to 3 times more likely to know their caregivers' names than were NESPs [See Table 16].

Table 16. Patients who knew staff members' names

<table>
<thead>
<tr>
<th></th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending physician</td>
<td>7 (54%)</td>
<td>12 (86%)</td>
</tr>
<tr>
<td>Resident</td>
<td>1 (4%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Nurse</td>
<td>4 (17%)</td>
<td>8 (35%)</td>
</tr>
<tr>
<td>Social worker</td>
<td>--</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Interpreter</td>
<td>6 (100%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Patient recognition of medical and nursing staff

Patients interviewed in this study were frequently confused about the identity of their attending physician. Many hospital patients assume that the physician in charge of their care is the doctor whom they see the most often; if they do not know their attending physician before being hospitalized, they may assume that the intern, another resident, or a even medical student is the head of the team providing care. Among the 46 patients in the matched groups this was a common mistake, especially for the NESPs.

While 13 of the NESPs interviewed replied that they had been visited by their attending physician, only 6 could actually distinguish the attending from among the other physicians treating them. Of these 6, 4 had known the physician before the hospitalization in question; the others
were well educated patients who made a concerted effort to know their caregivers. Six NESPs admitted that they were unable to tell the difference among their doctors. Three patients, 2 NESPs and an ESP, mistook their female attending physicians for nurses; one of these patients suspected that a Spanish-speaking male nurse was the attending.

ESP were able to identify their attendings correctly almost twice as often as NESPs. Among the 23 matched ESPs, 14 patients responded that they had been seen by their attending, 11 accurately. Seven of those 11 patients had known their attendings previously, while 4 had met them only after admission.

Many of the patients had a difficult time identifying their other doctors and distinguishing among the roles of the consulting physicians, residents, medical students, and sometimes even the nurses who visited them. Consulting specialists were the least recognized. It is likely that the majority of the patients in both groups had been seen by at least one consulting specialist by the time that they were interviewed. Most were surgery or OB patients who would have required an anesthesiology workup before surgery and a visit from an anesthesiologist afterward. A few of the medicine patients required gastroenterology and infectious disease consultations as well. It is possible that the the patients interviewed did not understand the concept of consultation, and that they saw no difference
between the tasks of the consultants and those of the rest of the medical team.

However, the responses to this question are quite important, as, in contrast to the other physician categories, twice as many NESPs as ESPs recognized the specialists who visited them. Of the 6 NESPs who responded that they had seen a specialist, 5 were OB patients who had spoken with a pediatrician. They remembered the pediatricians largely because the doctors either spoke Spanish themselves or were accompanied by a pediatric nurse who acted as an interpreter; most of these patients reported that the pediatrician had given them more information and reassurance than any other staff member. The remaining patient was also seen by a consultant who spoke fluent Spanish.

That these 6 NESPs were able to distinguish the consultants from their other physicians is especially noteworthy because only the last patient, who had known his Spanish-speaking internist for several years, knew whether he had seen his attending physician and could differentiate among the various doctors treating him. Conversely, all 3 of the ESPs who identified their specialists, also pediatricians, were able to distinguish among their other physicians. The fact that the NESPs could communicate in Spanish with the consultants appears to be the key factor in their ability to remember them.
Almost all of the patients in both groups correctly responded that they had been seen by one or more resident physicians, whom they often identified as the "young doctors". One NESP insisted that she had not been seen any doctor since admission, despite chart notes to the contrary; 1 ESP who was not on the teaching service also noted correctly that he had not been treated by any residents. Although most of the patients did know that they were being treated by different "young doctors", many, especially among the NESPs, were unable to differentiate between residents and medical students. Only 3 of the NESPs could distinguish the medical students from the housestaff; their judgment was based solely on the fact that the students were present only during rounds and never said or did anything by themselves. In contrast, 8 of the ESPs could tell the medical students from the housestaff and other physicians. While 3 of these ESPs also identified the students because their highly limited roles, 2 others recognized specifically that they had been interviewed and treated by students as well as residents.

While the American ESPs were more likely to assume that medical students were M.D.s, several NESPs who had grown up in other countries expressed the belief that even the residents were unlicensed practicantes, in keeping with the Latin American system of medical training. The responses of patients in both groups reflect the public's general
unfamiliarity with the stages of medical training and the clinical roles of the resident and medical student. However, the discrepancy between NESP and ESP rates of recognition suggest that the language barrier between NESP and their medical teams contributed to the confusion.

As in the case of attending physicians, the residents' gender had some effect on whether patients correctly identified them: 3 NESP and 1 ESP identified their female interns as nurses. Conversely, although all of the patients in both groups correctly stated that they had been cared for by nurses, 1 NESP and 1 ESP believed that their male nurses were physicians. Because information on practitioner gender was not specifically requested in the survey, but rather summarized from random patient comments, it is quite possible that the actual incidence of confusion would be higher. Similarly, some patients who did not know that they were being treated by medical students may have assumed that their female students were also nurses.

While this confusion occurred among the NESP with greater frequency than among the ESPs, in this instance the misunderstanding cannot be attributed simply to the language barrier: 2 of the female residents and 1 of the male nurses in question spoke fluent Spanish and spent considerable amounts of time with their patients. One NESP who had been told that his physician was a doctora expressed doubts that it was really true. Cultural presuppositions about
physicians and appropriate gender roles appeared to have had some influence on the NESP's ability to recognize their caregivers' actual positions.

Some suggestion has been made that patients become confused about staff roles when there is no clear difference between the dress of different professionals [Hughes & Proulx, 1979]. This factor is probably of limited importance here. Almost all of the physicians in the study hospital wear long white lab coats with their names, followed by the letters M.D., embroidered above the left breast pocket. Many doctors also wear name tags identifying them as physicians. Medical students wear short white jackets with the colored patch of the medical school and name tags. Both physicians and students on the surgery and OB services may wear scrub suits under their coats, but all other doctors and students wear street clothes of the style consistent with the stated preferences of most patients [Gjerdingen, Simpson, & Titus, 1987]. Although many of the nurses in the study hospital do carry stethoscopes, the traditional badge of the physician, all but a few of those involved in patient care, including male nurses, wear white uniforms. Only the nurses on the OB units and in the ICUs wear scrub suits; none of the clinical nurses wears street clothes.

The confusion over the identity of caregivers has been recognized to be quite disturbing to patients who may
already feel insecure in the unfamiliar setting of the hospital. Patients who cannot determine the roles of the individuals caring for them often become bewildered, angry, and anxious [Hughes & Proulx, 1979]. Moreover, because patients tailor their interactions with staff members to their presumed roles, they may have inappropriate expectations of professionals whom they cannot identify, leading to even more frustration when those expectations are not met [Mauksch, 1975; Tagliacozzo & Mauksch, 1979].

In addition, confusion over staff roles has serious implications for the authority of the physician, especially among patients who cannot ask questions of their caregivers because of a language barrier. The responses of the patients reported here indicate that NESPs who are unable to communicate with their doctors are less prone to recognize them, and more likely than other patients to place their confidence in staff members whom they can identify and with whom they can communicate. This phenomenon is illustrated by the 5 obstetric patients who remembered the pediatricians who spoke to them in Spanish, but were unable to identify their other physicians. While it is unlikely that the information that the pediatricians gave these women was wrong, it may not have been what their obstetricians would have said. However accurate or appropriate, the sum total of what these patients knew about their conditions was what the pediatricians had told them.
Still more troublesome is the fact that it is frequently not another physician who is able to communicate with the NESP and who is perceived as the authority figure. A few words from a nonmedical hospital employee in the patient's own language may have as great an impact on a NESP's perception of his or her condition and treatment as the physicians' actual medical intervention or anything that they might try to say. This problem is demonstrated in the case of the patient who mistook a Spanish-speaking male nurse for his attending physician. The nurse's reassurance that things would be all right were intended as comfort but the patient understood it as prognosis; the patient was convinced that his situation was not as serious as diagnostic tests, and the English-speaking physician, had indicated. Such misinformation may affect the patient's compliance with prescribed treatment and hinder recovery; reported later as part of a medical history, it may mislead future caregivers as well.

Recognition of allied health and social service personnel

As in the case of medical and nursing staff, the patient responses reported in Table 15 portray the rate of visits by other personnel to be roughly equivalent for NESPs and ESPs. However, these responses are seen to be similarly inaccurate when compared to data from patient charts and comments that NESPs made later in the interview.

In much the same way that consulting specialists were
not recognized by patients from either group, visits from therapists, particularly respiratory therapists, were widely underreported. Respiratory therapists visit most of the patients who have undergone surgery, as often as 6 times a day, to teach them breathing exercises and ensure that they have no respiratory difficulties. The majority of the patients interviewed would have seen and talked to a respiratory therapist.

However, only 2 patients from each group recognized the respiratory therapists. As with the consulting physicians, the NESPs who reported being contacted had been seen by therapists who spoke Spanish and who spent time talking to them. One ESP also commented that the therapist spoke Spanish. The 1 remaining ESP who recognized her therapists had been receiving daily physical therapy.

Few of the patients in either group reported having seen dieticians, and the many negative responses were confirmed by the patients' charts. One ESP mistook a medical student for a dietician because he had included questions about diet in taking her medical history. Although equal numbers of NESPs and ESPs were seen by dieticians, neither of the NESPs received a thorough dietary consultation. In one case the dietician simply opened the patient's mouth, checked the condition of her teeth, and left, telling the patient's roommate that she was a dietician.
Only 2 of the patients interviewed, 1 NESP and 1 ESP, were seen by social workers. Both had undergone treatment for serious conditions and qualified for disability benefits. The social worker who visited the NESP was accompanied by an interpreter, and spent roughly the same amount of time with her patient as did the social worker who contacted the ESP.

Although there appears to be little difference between NESPs and ESPs in the frequency of social service consultations, the NESPs' greater need for longterm care, lower rate of insurance coverage, and general unfamiliarity with the medical system suggests that NESPs should have received proportionally more attention than ESPs. As social workers must be called in by a physician, it is likely that some NESPs who could benefit from a social worker's help are never identified because of the language barrier between the patients and the medical staff.

The most marked difference between the rate of visits by ancillary personnel to NESPs and ESPs occurred among the chaplains. Two types of chaplains visit patients in the study hospital: members of the hospital's own chaplaincy program who are assigned entire nursing units to care for, and clergy from the community who visit patients identified as belonging to specific denominations. Of the 4 NESPs who reported having been visited by a chaplain, 2 were visited by priests from the diocese who gave them communion but said
nothing. Another was seen by a hospital chaplain who the patient claimed left the room immediately upon discovering that the patient spoke no English. Only 1 NESP had the chance to talk with a hospital chaplain, and then in a mixture of very broken English and Spanish.

These figures contrast sharply with the 10 ESPs who were visited by chaplains. While 1 ESP simply received communion from the diocesan priest, and 3 others were undergoing procedures or talking with visitors when the chaplains arrived and were unable to spend time with them, 6 did have an opportunity to confer with a member of the clergy. Five took advantage of the visit to talk about their hospitalization.

Hospital chaplaincy programs exist because hospital administrations and the clergy recognize that the sick need pastoral conversation, counseling, and reassurance [AHA, 1962; Wheelock, 1975]. Inasmuch as chaplains normally visit patients without waiting for a referral [Holst, 1985b], it is particularly ironic that NESPs would receive less attention from chaplains than from other members of the hospital staff. Because verbal communication is the chaplain's therapeutic tool, this low incidence of clergy visits to NESPs is a strong indication that the language difference is a significant barrier to NESPs' receiving care.

The patient representatives, who also serve as official
hospital interpreters, are the one group of ancillary personnel whom NESPs readily identified and who seldom saw ESPs. The only ESP who reported having been visited by a patient representative had been identified incorrectly by a nurse as needing translation assistance. But despite a specific duty to care for NESPs, only 9 of the NESPs reported having seen either a patient representative or an official interpreter.

Because the patient representatives in the study hospital visit patients only after a problem has been reported to them by another staff member, they often see only those NESPs with whom the staff finds it particularly difficult to communicate. NESPs identified as such upon admission are often visited spontaneously by interpreters before they are called, but many NESPs are admitted without that information being obtained. It is quite likely that the patient representatives' dependence upon other staff members to identify NESPs decreases their potential effectiveness in preventing communication problems and, in the long run, creates more work for them and unnecessary difficulties for the patients.

Only a few patients from each group reported having been visited by volunteers. Each of the volunteers identified by the ESPs had delivered something to the patients' rooms, and did not stay or talk to the patients themselves. The 2 NESPs who recognized the volunteers were
seen by Spanish-speaking visitors working for the patient representatives' office. Their specific job is to visit NESPs and their families informally and translate whenever necessary. Although they have the time and ability to talk to NESPs, both work for only a few hours one day a week, and they visited only those patients whom the patient representatives had already identified as NESPs.

From the responses of the patients in this study, the role of allied health and social service staff members in the care of NESPs appears to be much more limited than in the care of ESPs. Although this difference may be due in part to the fact that most such personnel work only at the request of a physician, who may be unaware of the NESP's nonmedical needs because of the language barrier between them, the comments of the NESPs interviewed here indicate that even after being called in, many of these caregivers do not spend the time with NESPs that they do with ESPs. The relationship between this phenomenon, the ability of patients and staff members to communicate with each other, and the patients' satisfaction with care is explored in the following sections.

Notes to Chapter 2

1. Moreover, as a certified interpreter in Spanish, I was able to interview Spanish speaking patients thoroughly in their own language, without having to rely on someone
else to translate for me.

2. Surgical services include: general surgery, trauma surgery, orthopedic surgery, plastic surgery, neurosurgery, urology, otolaryngology, and ophthalmology.

3. Although the Hispanic community of Houston is estimated to include some 500,000 persons [Anonymous, 1986; U.S. DCBC, 1982], there is very little specific demographic information about Hispanics in the Houston area either English-speaking or Spanish-speaking, available publicly (although a local marketing firm has information available to advertisers for a substantial fee). Unfortunately, therefore, the extent to which the study population is representative of the community at large is unclear. Census data is provided for comparison where available.

4. Latin American countries include: Chile, Colombia, Costa Rica, El Salvador, and Guatemala.

5. Information on the patients' immigration status was not requested, although 3 of the NESP subjects were known to have been in the country illegally.

6. See the section on patient satisfaction and expectations in Chapter 3, particularly pages 169-71.

7. As the term "attending physician" is unfamiliar to many people outside of medicine, the questionnaire used the terms "primary physician" and "medico de cabecera" instead. Patients' confusion about the identity of their physicians was likely not due to this wording, as patients were also asked about their attending physicians by name [See Appendix II].

8. To my frustration, no one in the hospital seemed able to identify either of these Spanish-speaking pediatricians or the Spanish-speaking "nurse" who accompanied the others. It is possible that they were from the large Preferred Provider Organization (PPO) clinic affiliated with the hospital, but none of the staff in pediatrics there could identify them either. As no information was discovered about them, they were not interviewed as part of the caregiver surveys.

9. Again, this is reported confusion, not independently documented. The large numbers of students and residents who see patients at any given time precluded the identification of them all for this purpose.
10. The patient representatives receive a listing of NESP's every few days from the computer center. The list includes only those patients identified upon admission to the hospital through the Admissions office as speaking no English. Since two-thirds of the Hispanic NESP's are admitted through the Emergency Room or Labor and Delivery, the list is always incomplete. Moreover, even those patients who come into the hospital through Admissions are not always recognized as NESP's (For more on this subject see the beginning of Chapter 5). Once a patient who speaks no English is discovered by the patient representatives, they try to visit him or her daily. However, many patients slip through the cracks and are never recognized.
Chapter 3
The Patients' Perspective on Communication with their Caregivers

The central purpose of the patient interviews was to examine the role that a language barrier plays in the communication between hospital patients and staff from the patients' perspective. One of the goals of the survey was to describe the nature of communication between NESPs and hospital personnel and to determine how it differs from communication between ESPs and their caregivers. Primary questions included: how NESPs and staff members communicate with each other; what form their verbal interaction takes; what kind of information is exchanged and how much the patients understand; and what NESPs know about their conditions and the treatment that they receive.

Moreover, the survey sought to describe patients' attitudes toward their hospitalization and interaction with staff members, including how NESPs feel about their linguistic isolation; whether they are satisfied with the extent of the communication that takes place, and whether they desire additional contact and discussion with their caregivers; and the importance that NESPs give to communication with hospital personnel when assessing their overall treatment.

It was anticipated that patients' unsolicited comments

108
would reveal their expectations of hospital care -- which might contribute to the way they interacted with caregivers, and examples of pleasant incidents and problems which might clarify their answers. Thus, although survey questions were designed to elicit information in a structured way, patients were given considerable latitude when they chose to illustrate their answers with specific examples. Their anecdotal remarks provided valuable insight into their experiences, and are cited or referred to here where appropriate.

**Interview Population and Methods**

The 77 Hispanic patients, 25 NESP, and 52 ESP, described in Chapter 2 were interviewed about their communication with the hospital personnel whom they had identified as having visited or treated them. In order to limit the effects of variables unrelated to language on the resulting data, only the responses of the matched population of 23 NESP and 23 ESP are examined in this section.

The core of the interview consisted of a structured series of fixed-alternative and open-ended questions about patient interaction with staff members from each of the 12 positions identified in the "Encounters" section of Chapter 2. Patients from both groups were asked 14 questions about their interaction with staff from each category: whether they and their caregivers talked to each other; how well they understood what the staff members said; whether they
had an opportunity to ask questions; and how satisfied they were with their caregivers' responses and overall care. NESPs were asked 3 additional questions about staff members' abilities to speak Spanish and the ways in which they tried to communicate with each other.

Wherever the patient reported having been visited or treated by a member of one of the 12 positions, he or she was surveyed about communication with personnel from that category. Patients were not surveyed about staff members who were present only to observe others' work, as was often the case with medical students. In all but 1 case, every patient was interviewed about his or her interaction with doctors and nurses.¹

In many instances, particularly in the case of the residents and nurses, the patient had been seen by several staff members operating in the same role. Rather than discussing each caregiver separately, patients were asked to answer the questions in terms of the members of that group in general, describing their typical encounters with them. To ensure that the resulting portrait was an accurate characterization of the group as a whole, the final question of each section asked whether every staff member in the category corresponded to that description. While a few patients singled out a specific individual for praise or criticism, almost all reported that their various caregivers displayed similar skills and behavior.
To determine the patients' knowledge and understanding of their conditions and treatment, both groups were also asked seven open-ended questions about their diagnoses, therapeutic regimens, and anticipated length of hospitalization. Their knowledge and comprehension was assessed by comparing their answers to similar questions put to their physicians and information obtained from their charts; the results are presented with the discussion of patient responses about communication with medical staff.

The importance of communication for patient satisfaction with overall care has been demonstrated repeatedly in clinic and hospital settings, with physicians from different specialties, and among patients of varied backgrounds. In light of these findings, the present study also examined patient satisfaction to identify whether limited communication resulting from a language barrier affected NESP's evaluation of their care. In addition to the questions on satisfaction included in each staff section, patients were asked to evaluate their overall hospital stays in four ways to ascertain what role, if any, communication with the staff played in their total satisfaction.

This chapter examines the results of the patient surveys, presented according to staff category and following the order of the survey itself: medical personnel (attending physicians and residents), nurses, and other staff. The
chapter concludes with a discussion of patient satisfaction with staff-patient communication, detailing what it involves and how it affects satisfaction with overall care. The distinctions and similarities between NESPs and ESPs on this point are examined, and a number of ethical questions are outlined for later consideration.

Interaction with the Medical Staff

Although many patients, both NESPs and ESPs, could not specifically identify their physicians and were unable to differentiate among the various medical personnel involved in their care, all but 1 patient reported that they had been seen by one or more doctors. Seventeen patients were asked about their interaction with their attending physicians, 41 were asked about their encounters with their residents, and 3 were asked about their interaction with the medical students.

The results of the surveys on patient communication with medical students are not included here because all of the patients who recognized the medical students as such, and who actually talked with them, were ESPs. As noted in the previous chapter, most of the patients were unable to distinguish medical students from residents. Inasmuch as the housestaff in the study hospital are the primary medical caregivers for all but a few nonteaching patients, only the resident section of the questionnaire was given to patients who were unable to differentiate among their medical
personnel. Although it is possible that some patients unknowingly referred to a medical student or attending in their answers, the residents' prominence in day-to-day treatment suggests that patients' responses would naturally focus on their behavior.

Attending physicians

Despite the relatively small number of patients included in this section of the questionnaire, the patients' remarks about their attendings are particularly important for this study. While only 6 NESPs and 11 ESPs were able to identify their attending physicians, 11 of these 17 had known their physicians prior to admission. Given their previous acquaintance, and in some cases their longterm relationships, language differences should figure more prominently than usual among factors hampering their communication, as doctor and patient had had earlier opportunities to establish a personal rapport and identify common goals [Waitzkin, 1985].

All of the 17 patients interviewed reported that their attending physicians did speak to them when they visited. For the NESPs, this interaction took a variety of forms. One patient reported that his doctor spoke fluent Spanish and talked with him in complete sentences, but the remaining 5 patients stated that their physicians were unable to communicate with them so directly or thoroughly [See Table 17]. Although 3 of the 5 stated that their attendings had
relied on another person -- most often a member of the patient's family -- to translate on one or more occasions, all 5 reported that the doctors usually used simple words in English and Spanish to ask questions and make statements. One patient reported that her attending often spoke to her in complete sentences in English, as if he assumed that she understood him easily. In 2 cases the patients mentioned that the attending often talked only to English-speaking family members or visitors.

Table 17. "How does your primary doctor usually try to communicate with you?"

<table>
<thead>
<tr>
<th>NESP</th>
<th>N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in Spanish</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Sentences in English</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Simple words in Spanish</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Simple words in English</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Through an interpreter</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Family member/visitor</td>
<td>2 (33%)</td>
</tr>
<tr>
<td>Hospital interpreter/staff</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Talks only to family/visitor</td>
<td>2 (33%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

In general, patients understood their attendings' questions and comments. Half of the NESP's responded that they usually understood everything or almost everything that their attendings said; 2 others reported that they usually
understood some of what their attendings said [See Table 18]. One NESP, however, insisted that he did not understand his attending at all, and that he relied on his wife to tell him later what the doctor had wanted. These figures compare to over four-fifths of the ESPs who claimed to understand their attending physicians very well.

Table 18. "How well do you usually understand what your primary doctor says or wants when he or she talks to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=6</th>
<th>ESPS N=11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>3 (50%)</td>
<td>9 (82%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>2 (33%)</td>
<td>2 (18%)</td>
</tr>
<tr>
<td>Poorly</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all</td>
<td>1 (17%)</td>
<td>--</td>
</tr>
</tbody>
</table>

What is ultimately important about these figures is not simply the percentage of patients who understood what their attendings tried to say, but the complexity of what was understood. It can be assumed that only the patient whose physician spoke fluent Spanish and the patient whose attending brought along an official interpreter could be given a thorough explanation of their status or treatment, or be asked comprehensive questions about their symptoms and daily needs. The other patient who claimed to understand her attending well tempered her statement with the remark that he often spoke in simple English and what she
understood were "routine words".

The patients who claimed to understand only some of what their doctors said also reported that their attendings usually spoke to them in simple English words, with occasional translation from a family member. Because of their limited understanding of even common English terms, these patients had access to only basic information about their care, and could give their doctors only such information as could be requested in the simplest words. The simplistic language that most of the physicians usually used was inadequate for real discussion of any topic. Even when a family member was present to translate, the physician's ability to communicate clearly with the patient was hampered because the family members often spoke only marginal English themselves.²

Research on patient comprehension has demonstrated that patients who experience difficulty in understanding are often confused by scientific terminology and shorthand medical jargon, especially when it is used in complex explanations which are beyond their everyday conceptual grasp [Korsch & Negrette, 1972; Waitzkin, 1984]. It is quite likely that the 2 ESPs who reported being occasionally unable to understand their attendings suffered from this phenomenon. However, it is unlikely that any of the 3 NESP\$ experienced this problem alone, and the figures for the 2 groups cannot be compared in any meaningful way. What 4 of
the NESP s understood or failed to understand was not
technical jargon or detailed accounts, but stark phrases in
the most basic language possible.

For their part, all of the patients, NESP s and ESP s,
reported that they also talked to their attending
physicians. However, two-thirds of the NESP s indicated that
they spoke only infrequently, while none of the ESP s
mentioned any such hesitancy [See Table 19]. Each of the
patients in question stated that they talked only a little
because they did not speak English and the attending would
not understand them if they spoke Spanish.

Table 19. "Do you talk to your primary doctor?"

<table>
<thead>
<tr>
<th></th>
<th>NESP s</th>
<th></th>
<th>ESP s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=6</td>
<td></td>
<td>N=11</td>
</tr>
<tr>
<td>Yes</td>
<td>6 (100%)</td>
<td>11 (100%)</td>
<td></td>
</tr>
<tr>
<td>[Little</td>
<td>4 (67%)</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

NESP s' efforts at communication with their attendings
were usually limited to simple words in English, although
when there was a family member present who spoke English or
the physician brought in an official interpreter the
patients did take advantage of their availability to
translate [See Table 20]. As in the case of the physicians'
abilities to talk to their patients, the NESP s' limited
English meant that they were typically able to express only
their simplest thoughts. Detailed statements or requests were not possible in such circumstances, and often NESP's were limited to answering their doctors' simple questions in equally simple statements of only one or two words.

Table 20. "How do you usually try to communicate with your primary doctor?"

<table>
<thead>
<tr>
<th>Method</th>
<th>NESP's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in Spanish</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Simple words in English</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Through an interpreter</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Family member/visitor</td>
<td>2 (33%)</td>
</tr>
<tr>
<td>Hospital interpreter/staff</td>
<td>1 (17%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

NESP's and ESP's largely agreed that their attending physicians gave them an opportunity to ask questions and discuss their concerns. Of the 2 NESP's who reported that their doctors gave them ample opportunity to ask questions, 1 patient had the attending who spoke fluent Spanish, the other's physician was accompanied by an interpreter [See Table 21]. The remaining 4 stated that their physicians provided some opportunity for discussion.

These latter responses are intriguing because of the extent to which these NESP's discussion with their attendings was impeded by the language barrier between them. Although their communication was usually limited to brief exchanges
in the most basic English, with an occasional exchange translated by a more fluent family member, these NESPs appear to have considered such interaction sufficient for their needs. Even the NESP who claimed to understand nothing of what his attending tried to say felt that he had some opportunity to ask questions. By contrast, 2 ESPs who both talked with and understood their physicians well maintained that they had little or no such opportunity.

Table 21. "Do you feel that your primary doctor usually gives you an opportunity to ask questions and discuss your concerns?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=6</td>
<td>N=11</td>
</tr>
<tr>
<td>Ample opportunity</td>
<td>2 (33%)</td>
<td>6 (55%)</td>
</tr>
<tr>
<td>Some opportunity</td>
<td>4 (67%)</td>
<td>3 (27%)</td>
</tr>
<tr>
<td>Little opportunity</td>
<td>--</td>
<td>1 (9%)</td>
</tr>
<tr>
<td>No opportunity</td>
<td>--</td>
<td>1 (9%)</td>
</tr>
</tbody>
</table>

All of the patients in both groups also reported being satisfied with the responses that their attendings gave to their questions and comments; importantly, two-thirds of the patients in each group claimed to be very satisfied with the way that the attending physicians answered [See Table 22]. Again, this is a curious finding for the NESPs, as the attendings were frequently unable to respond to them with anything more than the shortest, most elemental answers. Just as all but the simplest questions were impossible for
the patient, the doctors were prohibited from explaining in full sentences because of the language barrier.

Table 22. "Are you satisfied with the way that your primary doctor usually answers your questions?"

<table>
<thead>
<tr>
<th></th>
<th>NESP S N=6</th>
<th>ESP S N=11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>4 (67%)</td>
<td>7 (64%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>2 (33%)</td>
<td>4 (36%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Equally curious is that the NESP S who were "very satisfied" included the patient who understood nothing of what his doctor said, and a patient whose understanding was limited because her attending spoke only English. Inasmuch as 3 of the remaining NESP S received occasional translation for their interactions with the attendings, it is possible that the discussion then was sufficient to answer the patients' questions and instill in them a sense of confidence in their physicians which carried over though the dialogues in simplistic language. Nonetheless, it remains uncertain what sort of discussion could take place, as the translation provided by family members could not have been particularly clear. On the other hand, the patient who received official translation when she talked with her attending was one of the 2 who was less than fully satisfied
with the doctors' answers.

Asked about their attending physicians' overall care, all of the patients in both groups responded that they were satisfied with their treatment. All but one of the NESP's reported that they were very satisfied with their attendings' care [See Table 23]. Although satisfaction with care among the ESPs corresponds to the quality of their communication with attending, it appears to be largely unrelated to doctor-patient communication for the NESP's. While the NESP's opportunity for discussion and satisfaction with their physicians' responses roughly paralleled their satisfaction with care, neither their physicians' typical means of communicating nor the NESP's typical understanding correlated with that evaluation.

Table 23. "Aside from what you think of your primary doctor as a person, are you satisfied with the care that he or she gives you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP's</th>
<th>ESP's</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=6</td>
<td>N=11</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>5 (83%)</td>
<td>8 (73%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>1 (17%)</td>
<td>3 (27%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

The most common explanation for satisfaction among the NESP's was that their attending physicians "treated (them) well" or took "good care" of them [See Table 24]. In a
similar vein, 3 ESPs reported being satisfied because their attendings had helped them to get better, and 2 NESP2s were pleased because they believed that their doctors had made a special effort in treating them, although both still had a long hospital course ahead of them.

Table 24. "Why do you say that (you are satisfied)?"

<table>
<thead>
<tr>
<th></th>
<th>NESP2s N=6</th>
<th>ESP2s N=11</th>
</tr>
</thead>
<tbody>
<tr>
<td>He/she treats me well/ is attentive</td>
<td>3 (50%)</td>
<td>1 (9%)</td>
</tr>
<tr>
<td>I'm better/she/he helped me</td>
<td>--</td>
<td>3 (27%)</td>
</tr>
<tr>
<td>Makes an special effort/</td>
<td>2 (33%)</td>
<td>--</td>
</tr>
<tr>
<td>does his very best</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains/tells me things</td>
<td>--</td>
<td>3 (27%)</td>
</tr>
<tr>
<td>Trust him/her</td>
<td>--</td>
<td>2 (18%)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (33%)</td>
<td>2 (18%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

Three ESPs expressed satisfaction that their attendings explained their problems and treatment; another 2 responded that their satisfaction stemmed from the trust that their physicians inspired. However, none of the NESP2s raised the issue of communication in explaining their satisfaction -- the closest was a chronically ill patient who was thankful that her attending had made no promises about a cure, as she had been disappointed many times in the past by unsuccessful treatments.
Instead, NESP satisfaction appeared to be based in less tangible factors which included the attention that the attending gave to the patient and the effort that the physician appeared to make on the patient's behalf. How the patients defined "attentive" and "good treatment" is not clear from these few interviews, although it appears that neither concept necessarily involves conversation. A somewhat better definition of these terms, and the connection between communication and NESP satisfaction with care, emerges from the survey about the residents.

Interaction with the housestaff

While only a few patients were able to recognize their attending physicians, over 80% of both NESPs and ESPs were treated by and interviewed about their interaction with residents. As the residents are charged with total patient care, while the attending physicians' role is more supervisory, the patients' evaluations of their residents reveal more of their overall experience with doctors than do their assessments of the attendings. Moreover, where these latter surveys involved several patients who had known their physicians earlier, the interviews about residents portray the more typical situation in which doctor and patient meet as strangers. Their results demonstrate the role of differences in language as a barrier to good communication among a variety of obstacles to good rapport.

All of the patients from both groups reported that
their residents, like their attending physicians, talked to them when they visited [See Table 10]. Just over a third of the NESPs reported that they had at least one resident who was able to speak to them in conversational Spanish -- 5 in fluent Spanish; 5 patients indicated that their residents regularly talked to them in Spanish [See Table 25]. Three patients stated that their residents usually spoke to them through an interpreter, and 5 stated that their residents had spoken to them through an interpreter at least once.

Table 25. "How do the residents usually try to communicate with you?"

<table>
<thead>
<tr>
<th>Method</th>
<th>NESP  \ N=19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in Spanish</td>
<td>5 (26%)</td>
</tr>
<tr>
<td>Sentences in English</td>
<td>4 (21%)</td>
</tr>
<tr>
<td>Simple words in Spanish</td>
<td>3 (16%)</td>
</tr>
<tr>
<td>Simple words in English</td>
<td>6 (32%)</td>
</tr>
<tr>
<td>Through an interpreter</td>
<td>3 (16%)</td>
</tr>
<tr>
<td>Family member/visitor</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Hospital interpreter/staff</td>
<td>2 (11%)</td>
</tr>
<tr>
<td>Talks only to family/visitor</td>
<td>2 (11%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

However, another third of the patients responded that their doctors spoke to them directly in English without an interpreter, or that they talked only to an English-speaking family member or visitor without speaking to the patient at
all. As in the case of the attendings, almost half of the patients reported that their residents usually dealt with them in very simple English and Spanish words.

While several of the patients were able to speak freely with their residents in Spanish, a disturbingly high number of NESPs reported that they were usually unable to understand what their doctors were trying to say to them; just over half of the NESPs stated that they understood their residents poorly or not at all [See Table 26]. Only a third of the NESPs claimed to understand almost everything that passed between them, as opposed to just over 90% of the ESPs.

Table 26. "How well do you usually understand what the residents say or want when they talk to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=19</th>
<th>ESPs N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>6 (32%)</td>
<td>20 (91%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>3 (16%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Poorly</td>
<td>5 (26%)</td>
<td>--</td>
</tr>
<tr>
<td>Not at all</td>
<td>5 (26%)</td>
<td>--</td>
</tr>
</tbody>
</table>

While these figures are distressing in themselves, they are of even more concern when the differences in the content of the typical doctor-patient exchange are considered. Because, like the attendings, many of the residents often resorted to using simple words to speak to their NESPs,
whether in English or Spanish, it is unlikely that they were able to voice any but the most basic statements and questions in their visits. As noted in the previous section, the responses of the ESPs and NESPs to the question of patient comprehension cannot be compared on the same scale; for the ESPs it was a matter of understanding descriptions and explanations, while for many of the NESPs the issue was one of recognizing basic words and phrases.

NESPs themselves tended to be reticent with the housestaff; a quarter of them reported that they typically did not talk to their residents at all, and another third commented that they talked only very little [See Table 27]. The majority of these NESPs indicated that their silence was due to their inability to speak English, although 2 stated that they needed nothing and had nothing to say, and 3 replied that they spoke only when they had to answer their doctors' questions. Only 1 ESP expressed any such reluctance to talk to his residents, stating also that he spoke only to answer the doctors' questions.

Table 27. "Do you talk to the residents?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=19</th>
<th>ESPs N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14 (74%)</td>
<td>22 (100%)</td>
</tr>
<tr>
<td>[Little</td>
<td>6 (32%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>No</td>
<td>5 (26%)</td>
<td>--</td>
</tr>
</tbody>
</table>
Table 27a. "Why don't you talk to them?"

<table>
<thead>
<tr>
<th>&quot;No&quot;</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=5</td>
<td>N=0</td>
</tr>
<tr>
<td>I don't speak English</td>
<td>2 (40%)</td>
<td>--</td>
</tr>
<tr>
<td>They come when I'm asleep</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td>I need nothing/ have nothing to say</td>
<td>2 (40%)</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>&quot;Little&quot;</th>
<th>N=6</th>
<th>N=1</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don't speak English</td>
<td>3 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>Just to answer questions</td>
<td>3 (50%)</td>
<td>1 (100%)</td>
</tr>
</tbody>
</table>

Eight of the NESPs stated that they had been able to talk in Spanish with a Spanish-speaking resident at some time during their stay, and another 6 NESPs had had at least one opportunity to speak to their physicians through a translator [See Table 28]. Nonetheless, only 2 patients claimed to have regular access to translation in dealing with their residents, and in both cases the translator was a visiting family member or roommate. Over a third of the NESPs reported that relied on simple words in English to answer their doctors' questions and make simple requests. Three NESPs claimed that they expressed themselves in only simple Spanish words, 2 of whom said said that accompanied these short comments with gestures and facial expressions. Three of the NESPs maintained that they never talked to their doctors.
Table 28. "How do you usually try to communicate with the residents?"

<table>
<thead>
<tr>
<th>Method</th>
<th>NESP</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in Spanish</td>
<td>6</td>
<td>(32%)</td>
</tr>
<tr>
<td>Simple words in Spanish</td>
<td>3</td>
<td>(16%)</td>
</tr>
<tr>
<td>Simple words in English</td>
<td>7</td>
<td>(37%)</td>
</tr>
<tr>
<td>Through a hospital interpreter/staff member</td>
<td>2</td>
<td>(11%)</td>
</tr>
<tr>
<td>Gesture &amp; facial expression</td>
<td>2</td>
<td>(11%)</td>
</tr>
<tr>
<td>Never talk to doctors</td>
<td>3</td>
<td>(16%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

Despite the fact that well over half of the NESP\s were usually unable to understand what little was said by their residents, and that a similar number said little or nothing to their doctors in response, almost three quarters of the NESP\s reported that their physicians usually gave them an opportunity to ask questions and discuss their concerns [See Table 29]. These replies present the same apparent contradiction as the responses to the identical question involving attendings physicians: difficulties in communication notwithstanding, many of the NESP\s found that they had adequate opportunities for discussion.

Eighty-two percent of the ESP\s reported themselves to have had "ample opportunity" for discussion with their residents, as compared with only 47% of the NESP\s. There is
a significant difference (p<.05) between the NESPs and ESPs on this point, which suggests that language is a factor in the NESPs' opportunities for discussion with their doctors. Nonetheless, of the NESPs in this category, 5 stated that both they and their residents were usually limited to talking in simple English words, and almost half reported that they never initiated such discussion, speaking to their physicians only to answer questions.

Table 29. "Do you feel that the residents usually give you an opportunity to ask questions and discuss your concerns?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=19</th>
<th>ESPs N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ample opportunity</td>
<td>9 (47%)</td>
<td>18 (82%)</td>
</tr>
<tr>
<td>Some opportunity</td>
<td>7 (37%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Little opportunity</td>
<td>1 (5%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>No opportunity</td>
<td>2 (11%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Similarly, of the 7 NESPs who claimed that they had "some opportunity" to ask questions, 4 also maintained that they typically did not talk to their residents, and 2 others reported speaking only to answer their doctors' questions. While 3 of these patients communicated with their residents only in simple English and Spanish words, the remaining 4 NESPs had occasional opportunities to talk through a translator interpreter or with a Spanish-speaking staff member. From these figures it is difficult to draw any
direct correlation between NESPs' abilities to communicate with their residents and their assessment of the opportunities that they have for discussion.

Satisfaction with the residents' responses to patient questions and comments ran high among both the NESPs and ESPs: only 1 of the 41 patients expressed dissatisfaction. Among the ESPs there is a strong indication that such satisfaction is related to the patients' ability to communicate with their physicians. Of the almost 70% who were "very satisfied" with their residents' responses, all reported that they understood their doctors "very well", and all but 1 believed that they were given "ample opportunity" for discussion [See Table 30]. Conversely, the majority of those ESPs who were only "somewhat satisfied" with the way in which their residents answered their queries also reported that their opportunities for discussion or comprehension of the residents' comments were limited.

Table 30. "Are you satisfied with the way that the residents usually answer your questions?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=19</th>
<th>ESPs N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>10 (53%)</td>
<td>15 (68%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>8 (42%)</td>
<td>6 (27%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>N/A - don't ever talk with residents</td>
<td>1 (5%)</td>
<td>--</td>
</tr>
</tbody>
</table>
Half of the NESP's stated that they were "very satisfied" with their residents' responses, but there is no direct correlation between their level of satisfaction and either their reported comprehension of the residents' remarks or the opportunity that they had to ask questions. Of the 10 NESP's who claimed to be "very satisfied" with their residents' responses, 4 typically understood little or nothing of what their physicians said to them. All 4 reported that while the residents might have asked a family member to translate for the patient, they talked often talked only with that family member. Another 2 NESP's indicated that their residents always spoke to them in English, and that when the exchange went beyond very simple talk, they understood very little. Only 4 of the very satisfied NESP's regularly communicated with their residents directly in Spanish or through a hospital interpreter.

Similarly, half of the NESP's who reported themselves to be "somewhat satisfied" with their residents' responses usually understood little or nothing of what the doctors said to them. Although half also believed that they had "some opportunity" for discussion, the remaining patients indicated that the time available to them was quite divergent: 2 believed that they had "ample opportunity" for questions; 1 claimed to have "little" opportunity, and 1 had "none at all". Among this group as well, there appears to be no immediate link between the NESP's' satisfaction and
either their reported understanding of their residents, or their opportunity to discuss their own concerns.

The rate of satisfaction with overall care was high for both the NESPs and ESPs; again, only 1 ESP claimed to be dissatisfied [See Table 31]. Among the ESPs, correlation between satisfaction with care and quality of communication was evident. All but 3 of the 15 ESPs who reported that they were "very satisfied" with the residents' overall care had also claimed to be very satisfied with the responses that they received from them; all but 2 of the 15 felt that they had "ample opportunity" for discussion, and all but 1 believed that they understood their residents "very well".

Table 31. "Aside from what you think of the residents as persons, are you satisfied with the care that they give you?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=19</th>
<th>ESPs N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>11 (58%)</td>
<td>15 (68%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>8 (42%)</td>
<td>6 (27%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

All of the NESPs expressed satisfaction with the overall care that their residents provided; over half stated that they were "very satisfied" with their care. Here again, however, there was no direct connection between the NESPs' satisfaction and factors involving communication.
Although 80% of the NESPs who reported being "very satisfied" with their care had also been "very satisfied" with the way that their residents responded to their questions and comments, that latter satisfaction did not appear to be affected by their comprehension or opportunities for discussion. The fact that none of the NESPs reported themselves to be dissatisfied with their care again suggests that their satisfaction was based on criteria other than communication.

As in the case of the attending physicians, the most common explanation from both NESPs and ESPs for their satisfaction was that their residents "treated (them) well" or took "good care" of them [See Table 32]. As with those who made the same comments about their attendings, none of the patients specified what they meant by these phrases, but many emphasized their seriousness by repeating their answers several times.

Table 32. "Why do you say that (you are satisfied)?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=19</th>
<th>ESPs N=21</th>
</tr>
</thead>
<tbody>
<tr>
<td>They treat me well/ are attentive</td>
<td>9 (47%)</td>
<td>9 (43%)</td>
</tr>
<tr>
<td>I'm better because of them/ they help me</td>
<td>6 (32%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Listens to me/ understands</td>
<td>--</td>
<td>4 (19%)</td>
</tr>
<tr>
<td>Other</td>
<td>8 (42%)</td>
<td>5 (24%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
Among the ESPs, "good treatment" appears to involve good communication, as two-thirds of the patients who reported that their residents cared for them well also gave their communication the highest possible rating. While communication was certainly not the only factor in the ESPs' evaluation of care, it played a much greater part for them than for the NESP, for whom "good treatment" does not appear to have been affected by the quality of doctor-patient communication. Five of the NESP who reported being treated well had also stated that they were typically able to understand little or nothing of what their doctors said. Moreover, the only NESP who mentioned communication in stating that his doctors "treated (him) well", dismissed it as unimportant. He claimed that it did not matter that he did not understand residents; he knew what was wrong, and could tell that the doctors were concerned.  

NESP placed considerable value on the outcome of their treatment in assessing their satisfaction with care. Six expressed satisfaction that the residents were responsible for improvement in their conditions. One NESP was grateful that his doctors had made a big effort to save him, and another was simply pleased that her they gave her medicine.

While this sentiment was also voiced by 3 ESPs, 2 listed their improvement as only one of a number of factors. In contrast, good communication with the residents was the
second most common reason for satisfaction among the ESPs. Four ESPs listed their residents' willingness to listen and ability to understand as fundamental to their satisfaction. Moreover, the ESP who reported being dissatisfied with her residents' care, and 3 other ESPs who stated that their overall satisfaction was less than complete, cited problems in communication as their primary complaints [See Table 32a]. The first complained that she was "not very satisfied" because the residents dismissed what she told them as lies, and talked to her as if she could not be believed. The others insisted that they were only "somewhat satisfied" because they would have liked their doctors to have spent more time dealing with issues that the patients found important. One of these patients was particularly concerned that her residents were hiding something from her because they did not tell her enough about her condition.

Table 32a. "Why do you say that (you are not satisfied)?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs (N=0)</th>
<th>ESPs (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>They don't spend enough time with me</td>
<td>--</td>
<td>3 (75%)</td>
</tr>
<tr>
<td>They don't tell me anything</td>
<td>--</td>
<td>1 (25%)</td>
</tr>
<tr>
<td>They don't believe me</td>
<td>--</td>
<td>1 (25%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

Like the results of the attending physician section of the patient survey, the responses to questions about patient
interaction with the residents indicate that while the physicians spoke to all of their patients, the majority typically relied on simple words in English and Spanish in their dealings with NESPs. A Spanish-speaking physician or translator was available to most patients only occasionally. Unlike ESPs, who claimed to understand their physicians well, NESPs often failed to comprehend what their doctors wished to communicate. NESPs were hesitant to speak to their doctors, whether residents or attendings, because of their inability to speak English; when they did, they too were often limited to simple words in English and Spanish.

Regardless of their limited comprehension and frequent inability to speak to their doctors in full sentences, the majority of the NESPs believed that they had an opportunity for discussion with their physicians, and were satisfied with their doctors' responses. Their reported opportunities and satisfaction were not as great as those of the ESPs, but equally few from each group expressed dissatisfaction. Similarly, NESPs and ESPs were satisfied with the overall care provided by their physicians, often explaining that the doctors treated them well. While among ESPs this satisfaction can be associated with good doctor-patient communication, NESP satisfaction seems to be unaffected by such matters. It remains unclear why doctor-patient communication is not associated with satisfaction for both groups, although it appears that NESPs may consider the
doctor's effort at providing therapy and its eventual effects to be the essence of medical care, irrespective of his or her other behavior.

**Patient understanding of their conditions and treatment**

One of the major concerns that patients take to their physicians, if not their primary question, is the problem of "what is wrong". Diagnosis is much more than the determination of what has caused the patient's illness; not only does diagnosis determine treatment, it gives meaning to the patient's symptoms, thereby authenticating the illness and validating the sick person's social role as patient [Duff & Hollingshead, 1968; Janszen, 1978; Mechanic, 1978]. Moreover, by knowing the name of his or her disease the patient gains symbolic power over it. No matter how formidable the condition, in identifying it the patient is relieved of the anxiety of living with an undefinable ailment and its unpredictable course [Engel, 1977; Fabrega, 1975; Mechanic, 1972].

In addition to diagnosis, patients typically have 3 other vital questions when they turn to a physician: whether and how their ailments can be cured, and how long it will take to do so [Janzzen, 1978; Mechanic, 1972]. Because these are such fundamental issues, patients' ability to provide accurate answers to these questions is a ready measure of the quality of their communication with their doctors. All
of the patients in this study were asked a short set of questions about their diagnoses, the treatment that they had received, and their anticipated discharge date. Although many had come to the hospital with conditions whose origins were obvious, most notably the obstetric and trauma patients, even in such cases the patients' knowledge of what their diagnoses entailed was affected by the nature of their communication with their doctors.

The overwhelming majority of the patients -- all but 1 of the ESPs and 70% of the NESPs -- were able to describe their conditions in words which matched their official diagnoses and explain how those diagnoses had been determined [See Table 33]. Of the 37 patients whose descriptions matched very well, 6 NESPs and 6 ESPs were obstetric patients who clearly knew that they were in the hospital to give birth. Those patients who underwent caesarian sections -- 2 NESPs and 2 ESPs -- were able to explain the reasons for the procedure.

An additional 9 patients, 5 NESPs and 4 ESPs, were trauma victims with fairly straightforward injuries. All 4 ESPs gave descriptions of their conditions, including internal injuries, that matched their diagnoses very well. Three of the NESPs gave similarly good accounts of their diagnoses, but 2 demonstrated incomplete understanding of their conditions, consistent with their reports of limited communication in very simple English or Spanish.
Table 33. "What does the doctor say is wrong with you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=23</th>
<th>ESP N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matches well</td>
<td>16 (70%)</td>
<td>22 (96%)</td>
</tr>
<tr>
<td>Matches somewhat</td>
<td>2 (9%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Matches poorly</td>
<td>3 (13%)</td>
<td>--</td>
</tr>
<tr>
<td>Does not match at all</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
<tr>
<td>Don't know -- doctor hasn't said</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
</tbody>
</table>

The 10 NESP and 9 ESPs who had been diagnosed prior to admission to the hospital generally had good knowledge and understanding of their conditions; 8 ESPs' and 6 NESP's responses matched their diagnoses very well and 1 matched in part. However, despite previous treatment for the same problems, 2 NESP had quite poor understandings of their conditions, and 1 NESP claimed that no one had told her what was wrong. Each of these patients reported that their doctors spoke to them infrequently, often dealing instead with family members. Although he had been hospitalized many times, 1 NESP's description of his condition was completely inaccurate; it is likely, however, that his erroneous claim that his "ulcer" had healed was less the result of the language barrier than of the psychological problems in communication fostered by terminal illness.

The remaining 5 patients came to the hospital generally unaware of the causes of their symptoms. Nonetheless all 3
ESP's were able to explain their diagnoses well. One NESP had a similarly good understanding of his condition, due in large part to conversations with his Spanish-speaking resident. The remaining NESP had only the most limited knowledge of her diagnosis, and answered the question only after prompting. It is unlikely, however, that her poor understanding stemmed wholly from her inability to speak English, as both her intern (whom she thought to be a nurse) and her medical student spoke Spanish.

Patients' familiarity with the treatment which they received was considerably less complete than their understanding of their diagnoses, especially among the NESP's. Although over half of the NESP's described their treatment and its purposes well, a quarter of them could do so only poorly [See Table 34]. The remaining NESP's had some knowledge about their treatment, but could explain only that it was supposed to improve their particular condition. Similarly vague responses were given by 4 ESP's, but were much more common among the NESP's.

Most of the patients from both groups who had undergone surgery had a good understanding of what had been done and why, perhaps due to the surgeons' informed consent practices. The primary distinction between the ESP's and NESP's involved their knowledge and understanding of medication. The ESP's were generally aware of the type of medication that they received, and to a considerable extent
knew its intended effects. Many of the NESPs, by contrast, spoke only of the form in which their medication was administered (i.e. "pills", "shots", and "IVs"), and were seldom aware of what class of drugs they received.

Table 34. "What treatment have you had and what was it for?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=23</th>
<th>ESPs N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matches well</td>
<td>13 (57%)</td>
<td>18 (78%)</td>
</tr>
<tr>
<td>Matches somewhat</td>
<td>4 (17%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Matches poorly</td>
<td>6 (26%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Does not match at all</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

There was a widespread assumption among the NESPs that both pills and IVs were for pain, and although a number of NESPs were receiving intravenous antibiotics during their interviews, even those who drew attention to their IV poles did not know what they were being given. While this difference between NESPs and ESPs points directly to variations in the amounts of information that they received, it is likely that here the poor communication involved nurses rather than doctors, as it is the nurses who administer the drugs. Although such information could, and should, be given by the physicians, ample evidence exists suggesting that this job is often left to the nurses, who typically identify medications only when asked [Duff & Hollingshead, 1968; Mauksch, 1975]. Moreover, there is no
significant correlation between patients' recognition of their drugs and the way in which their doctors tried to communicate with them.

The patients' reported awareness of how long they would be hospitalized was influenced strongly by the fact that many, especially the NESPs, were interviewed at the end of relatively short stays. Although over 60% of the NESPs were accurate to within 1 day in reporting their estimated discharge dates, compared to only 30% of the ESPs, all but 4 of the NESPs were being discharged the day of the interview, compared to only 2 of the ESPs [See Table 35].

Table 35. "When do you expect to go home?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=23</th>
<th>ESPs N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matches well</td>
<td>14 (61%)</td>
<td>7 (30%)</td>
</tr>
<tr>
<td>Discharge today</td>
<td>10 (43%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Discharge tomorrow</td>
<td>1 (4%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Matches somewhat</td>
<td>1 (4%)</td>
<td>8 (35%)</td>
</tr>
<tr>
<td>Matches poorly</td>
<td>2 (9%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Does not match at all</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Don't know -- doctor hasn't said</td>
<td>6 (26%)</td>
<td>4 (17%)</td>
</tr>
</tbody>
</table>

If the figures are adjusted to account for this factor, however, the comparable rates of highly accurate responses are more similar: 31% to 24% [See Table 35a]. More
importantly, almost half of the NESPs in the adjusted population had no idea when they would be able to leave the hospital, compared to only 19% of the ESPs; in addition, the responses of almost 40% of the ESPs were correct to within 2 to 3 days. In all but 2 cases, 1 NESP and 1 ESP, the physicians had estimated their patients' discharge dates by the time that the patients were interviewed.\footnote{The difference between the NESPs' and ESPs' awareness of their physicians' plans likely reflects a tendency for the doctors to give NESPs less information about their progress, whether due to difficulty in communicating such information, or other reasons. There appears to be no direct relationship here between patients' knowledge and the means used by their physicians to communicate with them.}

\begin{table}
\centering
\begin{tabular}{lll}
 & \textbf{NESP} \textbf{N=13} & \textbf{ESP} \textbf{N=21} \\
\hline
Matches well & 4 (31\%) & 5 (24\%) \\
Matches somewhat & 1 (8\%) & 8 (38\%) \\
Matches poorly & 2 (15\%) & 4 (19\%) \\
Does not match at all & -- & -- \\
Don't know -- doctor hasn't said & 6 (46\%) & 4 (19\%) \\
\end{tabular}
\caption{"When do you expect to go home?" – adjusted}
\end{table}

As the earlier findings on the quality of NESPs' communication might suggest, NESPs' knowledge of their
conditions and treatment was only somewhat related to their reported understanding of their doctors and opportunities for discussion. The extent of their knowledge was unrelated to their general satisfaction with their doctors' responses to questions, and to the overall care that they received from them. ESFs' knowledge and understanding of their conditions and treatment, however, correlated highly with their understanding of their doctors' comments, opportunities for discussion, and satisfaction with care.

In sum, the patients' reports of their knowledge and comprehension of their diagnoses and the treatment that they received reveal that, while most of the patients had some grasp of what was wrong and what was being done to help them, the NESPs had much less information and a much more limited understanding of their conditions than did the ESFs.

The NESPs' reported understanding was closely related to the way in which the their doctors tried to communicate with them; consistently, the patients who knew the least about their conditions were those whose physicians dealt primarily with English-speaking family members instead of the patients themselves. These patients were followed by those whose doctors typically spoke to them in simple English.

The NESPs who understood the most about their conditions were those whose doctors periodically brought in an outside interpreter, and those whose doctors spoke Spanish. Spanish-speaking doctors were not a guarantee
NESPs knew what was happening, however, nor was their reported opportunity for discussion or satisfaction with doctors' responses. Moreover, from the NESPs' reported understanding of their treatment and progress, it appears that they had considerably less information available to them from their physicians than did the ESPs, irrespective of the way that their doctors tried to communicate.

These differences suggest that although the language barrier is a distinct factor, NESPs' communication with their doctors is limited less because of what the doctors are capable of communicating than because of physicians' assumptions about NESPs' need for information or habits in dealing with them. In keeping with earlier findings, NESPs' knowledge of their conditions and treatment did not affect their general satisfaction with their communication with their doctors, or the care that they received from them.

**Patient interaction with the nurses**

Unlike other members of the hospital personnel, every patient in the study was seen by and recognized a number of nurses. Although there was some confusion between nurses and medical staff due to gender stereotypes, all 46 patients in the matched population had regular contact with persons whom they knew to be nurses.

However, irrespective of the greater number of nurses involved in each patient's care and the greater frequency of their contact with their patients, the nurses were not as
likely as the doctors to talk to them. This was especially
ture for the NESP's, 5 of whom reported that their nurses
typically did not talk to them, and 4 of whom stated that
the nurses spoke only a little [See Table 36]. Most of
these NESP's believed that their nurses did not talk because
of the language barrier [See Table 36a].

Table 36. "Do the nurses talk to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP's</th>
<th>ESP's</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=23</td>
<td>18 (78%)</td>
<td>23 (100%)</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Little</td>
<td>4 (17%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>No</td>
<td>5 (22%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 36a. "Why do you think that they don't talk?"

<table>
<thead>
<tr>
<th></th>
<th>NESP's</th>
<th>ESP's</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't speak English/ wouldn't understand</td>
<td>3 (60%)</td>
<td>--</td>
</tr>
<tr>
<td>They're in and out fast</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NESP's</th>
<th>ESP's</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Little</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't speak English</td>
<td>1 (25%)</td>
<td>--</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (25%)</td>
<td>--</td>
</tr>
<tr>
<td>They just do their job</td>
<td>2 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>Only to answer questions</td>
<td>--</td>
<td>1 (100%)</td>
</tr>
</tbody>
</table>
The NESPs reported that when the nurses did speak to them, they spoke almost exclusively in English, typically in simple English words [See Table 37]. A small number of patients had a Spanish-speaking nurse or a nurse who called in an outside interpreter, but the nurses who tried to speak to the NESPs in their own language were usually limited to simple words in Spanish. A few nurses also tried to illustrate their simple statements and questions with gestures and facial expression. One patient reported that her nurses usually spoke to her through a family member who translated, but another stated that her nurses regularly spoke in English only to her family without talking to her directly.

Table 37. "How do the nurses usually try to communicate with you?"

<table>
<thead>
<tr>
<th>Method</th>
<th>NESPs N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in English</td>
<td>5 (22%)</td>
</tr>
<tr>
<td>Simple words in Spanish</td>
<td>5 (22%)</td>
</tr>
<tr>
<td>Simple words in English</td>
<td>17 (74%)</td>
</tr>
<tr>
<td>Through an interpreter</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Family member/visitor</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Gesture &amp; facial expression</td>
<td>3 (13%)</td>
</tr>
<tr>
<td>Talk only to family/visitor</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Nurses don't talk</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
Patients' comprehension of the nurses' remarks varied greatly. While all but 1 of the ESPs claimed to understand their nurses "very well", only 5 of the NESP's reported that they understood everything that their nurses said [See Table 38]. Five NESP's indicated that they usually comprehended some of what was said to them, but over half of the NESP's claimed that they typically understood little or nothing.

Table 38. "How well do you usually understand what your nurses say or want when they talk to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP's N=23</th>
<th>ESP's N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>5 (22%)</td>
<td>22 (96%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>5 (22%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Poorly</td>
<td>6 (26%)</td>
<td>--</td>
</tr>
<tr>
<td>Not at all</td>
<td>6 (26%)</td>
<td>--</td>
</tr>
<tr>
<td>N/A - nurses don't talk</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
</tbody>
</table>

As with the NESP's and their doctors, what was comprehended by even those NESP's who understood "very well" can only be described as very basic questions and instructions, as the nurses of the NESP's who claimed to understand typically spoke to them in simple English words. There was no correlation between the nurses' reported use of simple Spanish words and the patients' understanding, suggesting that what Spanish was used was either extremely simplistic or incorrect.
While the ESPs indicated that they were more likely to talk to their nurses than to their physicians, NESPs reported just the opposite. A third of the NESPs claimed that they typically did not speak to their nurses, and another third stated that they rarely talked [See Table 39]. Again, the most common reason given by those who did not talk was that they did not speak English [See Table 39a].

Table 39. "Do you talk to the nurses?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=23</td>
<td>N=23</td>
</tr>
<tr>
<td>Yes</td>
<td>15 (65%)</td>
<td>23 (100%)</td>
</tr>
<tr>
<td></td>
<td>[Little</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 (35%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>No</td>
<td>8 (35%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 39a. "Why don't you talk to them?"

<table>
<thead>
<tr>
<th>&quot;No&quot;</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=8</td>
<td>N=0</td>
</tr>
<tr>
<td>I don't speak English</td>
<td>6 (75%)</td>
<td>--</td>
</tr>
<tr>
<td>They're in and out too fast</td>
<td>1 (13%)</td>
<td>--</td>
</tr>
<tr>
<td>I don't need anything</td>
<td>1 (13%)</td>
<td>--</td>
</tr>
<tr>
<td>&quot;Little&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't speak English</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only to answer questions</td>
<td>2 (40%)</td>
<td>--</td>
</tr>
<tr>
<td>Only to ask for something</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td>I'm in too much pain</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td>I'm shy</td>
<td>--</td>
<td>1 (100%)</td>
</tr>
</tbody>
</table>
When NESPs did speak to their nurses, almost half usually relied on simple words in English, and a third used simple Spanish [See Table 40]. As would be expected, the patients classified as "poor" speakers of English for the purposes of this study were more likely to attempt to use English than were those NESPs whose English skills were rated as "none at all". Given the very limited English of even the "poor" NESPs, it is clear that the typical exchange from NESP to nurse had to be extremely short and simplistic.

Table 40. "How do you usually try to communicate with the nurses?"

<table>
<thead>
<tr>
<th>Method</th>
<th>NESP Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=23</td>
<td></td>
</tr>
<tr>
<td>Sentences in Spanish</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Simple words in Spanish</td>
<td>8 (35%)</td>
</tr>
<tr>
<td>Simple words in English</td>
<td>11 (48%)</td>
</tr>
<tr>
<td>Through an interpreter</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Family member/visitor</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Gesture &amp; facial expression</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Don't talk to nurses</td>
<td>4 (17%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

Although 1 patient often spoke to nurses through an English-speaking family member, this communication was also likely to have been limited, as this "translator's" English skills were only slightly better than the patient's. Two
patients who claimed that they were often able to communicate with their nurses through gestures when words failed them were also clearly restricted to the most basic requests and statements. Still more limited were the 4 patients who maintained that they typically never spoke to their nurses.

Patients in the 2 groups gave widely divergent accounts of the opportunities for discussion afforded them by their nurses. Although the majority of all patients reported that they had an opportunity to ask questions of their nurses, only a quarter of the NESP's believed that they had "ample opportunity", compared with 60% of the ESP's [See Table 41]. Roughly a quarter of the patients from each group reported that they had little or no opportunity for discussion, with 3 of the 5 NESP's in question stating that they had no opportunity at all.

Table 41. "Do you feel that the nurses usually give you an opportunity to ask questions and discuss your concerns?"

<table>
<thead>
<tr>
<th></th>
<th>NESP's N=23</th>
<th>ESP's N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ample opportunity</td>
<td>6 (26%)</td>
<td>14 (61%)</td>
</tr>
<tr>
<td>Some opportunity</td>
<td>9 (39%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Little opportunity</td>
<td>3 (13%)</td>
<td>5 (22%)</td>
</tr>
<tr>
<td>No opportunity</td>
<td>3 (13%)</td>
<td>--</td>
</tr>
<tr>
<td>N/A -- don't ever talk</td>
<td>2 (9%)</td>
<td>--</td>
</tr>
</tbody>
</table>
Among the NESP the reported opportunity for discussion appeared to have little connection to either the nurses' means of communicating or to the patients' understanding of the nurses' comments. Moreover, all of the NESP who stated that their nurses usually talked to them only a little reported that they had an opportunity for discussion with the nurses; 1 NESP claimed that she had "ample" opportunity. Even 2 of the NESP who maintained that their nurses typically did not talk to them at all reported that they had some opportunity to ask their nurses questions. In addition, 4 of the 6 NESP who claimed that they had "ample opportunity" for discussion typically spoke little to their nurses themselves, and of the 9 NESP who reported that they had "some opportunity, 2 reportedly also spoke only rarely, and 3 claimed that they usually did not speak to their nurses at all.

Regardless of their perceived opportunity for discussion, patient satisfaction with the nurses' replies to their questions and comments was considerably higher among the ESPs than among the NESP. Although all but 2 patients in each group expressed satisfaction with their nurses' responses, the ESPs were more than twice as likely as the NESP to report themselves to be "very satisfied" with the nurses' replies [See Table 42]. Three-quarters of the ESPs stated that they were "very satisfied" with their nurses' responses, compared to less than a third of the NESP.
Table 42. "Are you satisfied with the way that the nurses usually answer your questions?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=23</th>
<th>ESPS N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>7 (30%)</td>
<td>17 (74%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>11 (48%)</td>
<td>6 (26%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>2 (9%)</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>N/A - don't ever talk</td>
<td>3 (13%)</td>
<td>--</td>
</tr>
</tbody>
</table>

The NESP, who were more likely to report that they were only "somewhat satisfied" with their nurses' responses, demonstrated no clear correlation between satisfaction and patient comprehension. Three NESP who indicated that they typically did not understand their nurses' remarks claimed nonetheless that they were "very satisfied" with them. The patients who reported being "somewhat satisfied" with their nurses' responses were also divided on the issue of comprehension, with 5 reporting that they understood little or nothing. The strongest connection between satisfaction and comprehension was demonstrated by the 2 who claimed to be "not very satisfied" with their nurses responses, which they were unable to understand.

There was similarly little relationship between the way in which the nurses tried to communicate with their NESP and the patients' reported satisfaction with their answers. The nurses of 4 of the NESP who were "very satisfied" spoke...
to their patients in nothing but simple English. The nurses of the remaining 3 occasionally spoke to them through an English-speaking family member or staff member, but also relied heavily on simple English. Use of simple Spanish and even translation did not ensure patient satisfaction, however; 5 patients who received occasional translation from both family and staff members, expressed limited satisfaction, and 1 claimed to be "not very satisfied".

There were also mixed responses among the NESP's who reported that their nurses spoke to them little or not at all. Of the 6 patients who answered the question, 1 whose nurses typically did not speak claimed to be "very satisfied" with their responses and 3 were "somewhat satisfied"; only the remaining 2 were "not very satisfied". Although all but 2 of the 15 NESP's who reported having an opportunity to ask questions were satisfied with their nurses' responses, so, too, were 3 of the 4 NESP's who claimed to have little or no such opportunity.

ESP satisfaction paralleled both patient comprehension and assessment of opportunities for discussion. Of the 17 patients who were "very satisfied", 14 also reported that they understood everything that the nurses said and they had "ample opportunity" to talk with them. Conversely, 4 of the 6 who were only "somewhat satisfied" believed that they had "little opportunity" for discussion.

Patient satisfaction with overall nursing care was also
generally high, although still greater among ESPs than among
NESP s. Where 70% of the ESPs were "very satisfied" with the
care that they received, NESP s were split almost evenly
between "very satisfied" and "fairly satisfied" [See Table
43]. Only 1 ESP claimed to be dissatisfied with the nursing
care that she received.

Table 43. "Aside from what you think of the nurses as
people, are you satisfied with the care that
they give you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP s N=23</th>
<th>ESP s N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>12 (52%)</td>
<td>16 (70%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>11 (48%)</td>
<td>6 (26%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

As in the case of medical care, the ESPs' overall
satisfaction with the nurses correlated strongly with
factors involving communication. Seventy-five percent of
the ESPs who reported being very satisfied with their
nursing care also gave every aspect of their communication
with the nurses the highest possible rating. The patient
who claimed to be "not very satisfied" with the care that
she received believed that she had little opportunity to
talk with her nurses and said that she could not tell
whether they understood what she said to them.

However, the NESP s' reported satisfaction with their
nurses, again in keeping with their assessment of their physicians, appeared to be largely independent of factors involving communication. The nurses' tendency to speak to their patients did not seem to affect NESPs' satisfaction: 1 NESP whose nurses typically did not talk to her reported herself to be "very satisfied" with the overall nursing care, as did all but one of those whose nurses spoke only a little. The remaining patients whose nurses did not speak still reported that they were "somewhat satisfied" with their overall care.

There was no correlation between satisfaction with care and the means which the nurses used to communicate with their NESPs. Patients who were "very satisfied" with their care were as likely to have communicated with their nurses exclusively in English as through an English-speaking family member or interpreter. Nor was comprehension a determining factor for satisfaction: 5 of the 11 NESPs who were "very satisfied" claimed to understand little of what their nurses said, and 2 typically understood nothing at all.

Although the NESPs' satisfaction with their overall care did not correlate with their assessment of their opportunities for discussion, it did parallel their satisfaction with the nurses' responses to questions and comments. Seventy percent of those who were "somewhat satisfied" with their care had also been "somewhat satisfied" with their nurses' responses; almost 60% of those
who were "very satisfied" with the nurses' care had been similarly "very satisfied" with their responses. However, as shown, the NESP's satisfaction with nurses' answers to their questions bore no relationship to their typical comprehension or the frequency of nurse-patient discussion, and the apparent connection between their high marks in the 2 categories of satisfaction is difficult to maintain.

The majority of both NESP's and ESP's again tended to explain their satisfaction with the nurses in terms of "good treatment" [See Table 44]. For many patients from both groups "good treatment" meant that "attentive" nurses were regularly available to help the patients, and that they came when they were needed.

<table>
<thead>
<tr>
<th></th>
<th>NESP's N=23</th>
<th>ESP's N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td>They treat me well/</td>
<td>11 (48%)</td>
<td>16 (73%)</td>
</tr>
<tr>
<td>are attentive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>They do what I need/</td>
<td>9 (39%)</td>
<td>--</td>
</tr>
<tr>
<td>I never need anything</td>
<td></td>
<td></td>
</tr>
<tr>
<td>They talk to me/</td>
<td>--</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>explain things to me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5 (22%)</td>
<td>4 (18%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

The ESPs focused many of their comments on the nurses' communication skills. In several cases ESPs complimented their "attentive" nurses on their friendliness; in 3
instances the patients specifically mentioned the fact that
the nurses were available for conversation, and that they
were good at explaining. In addition, the only ESP
complaint concerned a problem in communication. The woman
who was dissatisfied with her nurses complained that they
had treated her roughly when she did not respond immediately
to their request to move. The patient suggested that the
nurses assumed that she did not understand them and resorted
to "mean" physical treatment when they thought that they
could not communicate with her.

None of the NESPs, however, mentioned such factors in
explaining their evaluations of the nursing care, suggesting
again that good communication is relatively unimportant to
overall NESP satisfaction. As in the case of their
discussion of medical care, it is not entirely clear how the
NESPs defined "good treatment" or "attentive" nursing care.
A few patients also commented about their nurses' frequent
visits and efficiency, but their understanding of good
nursing care in this context remains vague.

However, an almost equally large number of NESPs
claimed that their satisfaction resulted from the nurses' good service; these patients praised the nurses for
anticipating and meeting their needs. Many were
particularly impressed that the nurses would be "right
there" when they needed something; two specifically
mentioned "needs" met by the nurses were medication and
shampoo. Others were simply pleased that they could call their nurses, even though they never did.

These 9 NESP's were split between "very" and "somewhat" satisfied with their nurses' overall care, reflecting the split in the total NESP population, and their statements may provide some important insight into the typical NESP basis for judgment. Many of the patients who expressed satisfaction with nursing care as service spoke infrequently with their nurses if at all, and then on a very superficial level. In light of the demonstrated poor correlation between good nurse-patient communication and overall patient satisfaction, it seems appropriate to conclude from these comments that to many NESP's the nurses' job is task oriented and does not necessarily include meaningful, frequent, or even intelligible conversation with the patients being "served".

In summary, where the typical ESP was able to speak with his or her nurses more freely and with greater understanding than with his or her physicians, the experience of the average NESP was just the opposite. The NESP's' nurses almost always spoke to them in English, which even when restricted to extremely basic words, the patients seldom understood. While a few nurses also used simple Spanish, it did not improve the patients' overall comprehension.

The majority of the NESP's reported that they typically
did not speak, or spoke only a little, to their nurses, largely because of the language barrier. Few NESP's had access to good translation, and many believed that they had only limited opportunities for discussion with their nurses. Nonetheless, most of the NESP's were satisfied with the responses that the nurses gave when they did ask questions, and despite the poor quality of their communication with the nurses, all were ultimately satisfied with the overall nursing care that they received. The reasons for their satisfaction differed, however, in ways which suggest that the NESP valued good service from their nurses much more than the good communication valued by the ESP's.

**Interaction with other personnel**

As discussed in Chapter 2, very few patients reported that they had been visited by allied health or social service staff members who actually spoke to them. Because such a small number of patients were able to respond to this portion of the questionnaire, only a brief review of the patients' responses and a summary of the limited implications of these findings are presented here; a complete breakdown of patient answers by staff category is presented in Appendix IV. However, inasmuch as almost half of the NESP's commented on their interaction with patient representatives or other interpreters, and due to the special nature of their work, the patients' responses to this section of the interview are discussed here more fully.
To some extent, the means used by the staff members to communicate with the NESPs reflects the complexity of their interaction. The NESP who met with a social worker for an hour reported that they talked exclusively through a hospital interpreter. One NESP reported having received a careful explanation from a Spanish-speaking respiratory therapist, and a second claimed that he had a friendly chat in Spanish with a chaplain. Both of the remaining patients reported that they communicated with the staff members -- several respiratory therapists and a dietician -- in simple words in English and Spanish.

The 3 NESPs who talked with their caregivers in Spanish reported that they understood them very well; the 2 others indicated that they understood fairly well. All but 1 of the 5 believed that they had an opportunity to ask questions, and were satisfied with the way that their questions were answered. However, the patient who spoke with the chaplain was probably heavily medicated at the time, and the patients who claimed to understand their staff members' simple words had extensive experience with the treatment that they were receiving. The ESPs' responses to this section of the survey were almost unanimous: all of the ESPs understood their allied health and social service caregivers very well, all but 1 believed that they had ample opportunity for discussion, and all but 1 were very satisfied with the way that the staff members answered their
questions.

All of the patients from both groups indicated that they were satisfied with the overall care that they received from these personnel. However, the ESPs expressed greater satisfaction than did the NESPs: 82% of the ESPs reported that they were very satisfied with their care, whereas only 20% of the NESPs were very satisfied. Although there appears to be a connection between the quality of staff-patient communication and the patients' satisfaction with care, the difference is not significant because of the extremely small numbers involved.

Again, there appeared to be only a limited connection between NESPs' evaluation of their care and factors involving communication. Only 1 NESP -- whose therapist spoke fluent Spanish -- based his assessment on communication. The patient who rated his interpreted communication very highly was only fairly satisfied with the social worker's care. Two NESPs did not know why they were satisfied. The ESPs, in contrast, continued to focus on their communication with the staff in assessing their care. Three patients expressed satisfaction that their caregivers had explained things well or spent time talking with them; 2 others were pleased just to have been invited to talk. Ironically, 2 ESPs were quite happy that allied health personnel had spoken to them in Spanish.

Although the number of patients able to respond to this
section of the interview was too small to provide significant results, their responses echo those of previous sections. The NESP's interaction with their caregivers was often compromised by the language barrier, yet unlike the ESPs, who based much of their assessment of the staff on their communication skills, NESP's appeared largely indifferent to the quality of that communication.

**NESP interaction with patient representatives/interpreters**

Nine of the NESP's reported that they had talked with a member of the patient representative staff, and another 3 stated that their doctors or nurses had brought in interpreters who could not be identified. Although there are obviously no ESP evaluations of these personnel against which to compare those of the the NESP's, the NESP's comments are important in themselves as an indication of the role that interpreters can have in treating patients who speak no English.

It was usually a physician who called a patient representative for translation assistance, although some patients also reported that their nurses had asked an official interpreter to talk to them. Almost always the staff member needed an interpreter to convey very specific and sometimes detailed information, or obtain equally specific information from the patient. In a few instances, the NESP's doctor called for an official interpreter to translate an informed consent document; both physicians and
nurses used official interpreters to explain necessary self-care, especially after surgery or childbirth. Several patients also reported that the patient representative whom they had seen as an interpreter returned later just to visit.

As might be expected, all 9 of these NESPs reported that they spoke with their patient representatives/interpreters exclusively in Spanish and that they were able to understand what passed between them very well. All 9 believed that they had an ample opportunity to ask questions, and were very satisfied with the way that they were answered. Their total satisfaction was also very high: every patient reported being very satisfied with the overall care that they had received from their interpreters.

Inasmuch as facilitating good communication is the essence of the interpreters' "care", it is not surprising that the reasons for the patients' satisfaction focused on communication. Nonetheless, several of the patients were insistent that they would not have been able to understand anything without the interpreters, and that they were very good at explanations. Even such highly positive evaluations do not fully reflect the overwhelming gratitude expressed by several NESPs for an opportunity to speak with a staff member in Spanish.

Central to the patient representatives' definition of their role as interpreters is the need to act as advocates
for patients who speak no English. They not only try to ensure that NESPs fully understand translated information and its implications, they also encourage their patients to ask questions. The value of such advocacy is suggested by the patient evaluations of the 5 unidentified persons who translated for them. Although the patients for whom these individuals provided translation reported that they easily understood the translators' fluent Spanish, they were much less enthusiastic about their service than the patients who were seen by official interpreters. One patient claimed that she had limited opportunity for discussion, and was only somewhat satisfied with the way that the unidentified translator responded to her; another insisted that she had no opportunity at all to ask questions. Only one unofficial translator provided care that was fully satisfactory in the eyes of her patient.

While neither the actual quality of the interpreters' translations nor the amount of information that they conveyed can be assessed from the patient surveys, it is evident that the patient representatives' dedication to providing information coherently and enhancing communication generally received a positive response from the NESPs whom they served. But, because an interpreter only transmits to a patient information from another source, the NESPs' favorable reaction to the advocate interpreters suggests that they would appreciate good direct communication with
other caregivers, despite their earlier indications of apathy. A comprehensive examination of NESP satisfaction with communication in medical care, considered in light of other research on patient satisfaction, helps to reconcile these apparently contradictory findings.

**Communication and Patients' Satisfaction with Care**

As discussed in Chapter 1, an extensive body of literature on communication in medical settings presents a strong argument that the quality of communication between doctor and patient is the principal determinant of the patient's satisfaction with overall care. Irrespective of demographic variables, patients have been shown to want attention, empathy, and information from their doctors; these factors have been shown repeatedly to outweigh all others, and good communication skills are essential to providing each of them [DiMatteo & Hays, 1980; Locker & Dunt, 1978; Murphey-Cullen & Larsen, 1984; Pendelton, 1983; Reynolds, 1978; Waitzkin, 1984; 1985]. Lay people, particularly uneducated people with limited technical expertise, evaluate the care that they receive according to the quality of their rapport with the caregiver and his or her communication skills [Ben-Sira, 1976; DiMatteo & Hays, 1980; Segall & Burnett, 1980].

Considered against these conclusions, the results of the present survey are quite startling. Although the ESPs' reported satisfaction with their care correlated well with
the quality of their communication with their doctors, the NESP's reported similarly high satisfaction irrespective of factors of communication. Despite their own clear indication that their communication with caregivers was typically infrequent, poorly understood, and extremely superficial, none of the NESP's expressed dissatisfaction with their caregivers, and many claimed to be very satisfied with the care that they received.

Why do the NESP's' sentiments seem to vary so greatly from those of thousands of patients involved in communication studies over the past 20 years? It is conceivable that their responses were particularly influenced more strongly than usual by the "halo effect" noted in several satisfaction studies: patients may be unable to report dissatisfaction accurately immediately after a medical consultation because their need for confidence in their caregiver is the greatest then [Pendleton, 1983]. This influence is thought to play a large part in the reported satisfaction of hospital patients because their need to trust their doctors, nurses, and the hospital itself extends throughout their hospitalization [Kutner, 1958; Mauksch, 1975]. NESP's may be more susceptible to this effect than others because of the greater psychological and emotional investment that they must make to leave the security of a Spanish-speaking environment to come into the English-speaking hospital.
It is also possible that the NESPs were less certain about the neutral role of the researcher and, despite assurances of confidentiality, less willing to report dissatisfaction for fear of abandonment or retribution if their sentiments became known. Of the NESPs who originally refused to participate in the study, roughly half voiced an unwillingness to talk about their care because they were afraid that the staff would become angry with them for complaining to an outsider.

Another possible explanation is that the NESPs' responses were influenced by cultural factors that do not affect other studies. The bulk of the research on doctor-patient communication and patient satisfaction has been conducted by American, British, and Canadian investigators whose patient-subjects' backgrounds, while perhaps diverse for the locales in which the studies were carried out, are nonetheless heavily "Anglo". While the ESPs in this study are also Hispanic, most have had significantly more exposure to Anglo values than their NESP counterparts. The NESPs' explanations for their reported satisfaction with care suggest that other factors may be more important to them than communication, factors which might be particularly important to Hispanics. Unfortunately, there is no similar research into Hispanic satisfaction with doctor-patient communication available for comparison.
Although each of these factors may have some role in the study's surprising results, other conclusions may be drawn from this same literature on satisfaction which support both a universal desire for good communication in medical care and the NESPs' apparently contradictory responses. Of particular importance here is the research of physician and social scientist Howard Waitzkin, whose investigation into communication between physicians and patients of different backgrounds confirms that there are identifiable connections between patients' socioeconomic characteristics and their doctors' tendencies to give them information [Waitzkin, 1984]. Waitzkin determined that despite patients' equal desires for information, physicians spend more time with and provide more information to patients who are educated, upper-middle class, older, and female, over those who are poorly educated, working class, young, or male. This finding has been confirmed by subsequent research conducted by physicians and public health researchers Arnold, M. Epstein, William C. Taylor, and George R. Seage, who observe such differences across physician specialties and practice characteristics [Epstein, Taylor, & Seage, 1985].

The important distinction that Waitzkin has identified between these groups is sociolinguistic: patients of different backgrounds express their desire for information differently, and because of their class-linked patterns of
interacting with others, what some patients say, or more importantly do not say, may not reflect what they want to know from their doctors [Waitzkin, 1985]. In Waitzkin's study, patients from lower class backgrounds received little information about their conditions and treatment because, based on their tendency not to ask questions, their doctors assumed that they did not want or need such information.

Waitzkin's focus on the behavior of the typical poorly educated, working class patient provides some important insight into the situation of the NESPs in the English-speaking hospital. Citing early investigations in which such patients were found to be quite passive with both doctors and nurses [Cartwright, 1964; Pratt, Seligmann, and Reader, 1957], Waitzkin has outlined several explanations for patient diffidence, two of which specifically involve sociolinguistic variables that suggest motives for the NESPs' conduct and evaluations.

Waitzkin's working class patients were often intimidated by their doctors' elevated social position. Clearly, most of the NESPs fit Waitzkin's profile of the poorly educated working class patient, and in all but a few cases, their interaction with caregivers was undoubtedly affected by a considerable difference in socioeconomic background. This in itself would not be enough to distinguish the NESPs from the ESPs, whose demographic characteristics were deliberately similar. However, because
the NESP's were more recently a part of the stratified society of Latin American than the more acculturated ESPs, it is likely that the NESP's perceived a greater distance, irrespective of what actually was the case. Moreover, given the discrepancy in their levels of education, the NESP's were probably more in awe of the special knowledge and powers posessed by the medical professionals.  

Nonetheless, it is Waitzkin's second set of findings that helps to explain the tremendous differences between the NESP's and ESP's reported quality of communication and respective evaluations of care. Waitzkin found that the diffidence fostered by working class patients' high esteem for their caregivers is aggravated by their common, and often correct, belief that no one expects them to ask questions. What little they know about their conditions and treatment is limited to what their doctors tell them voluntarily, and they ask no questions in an effort to meet what they believe to be the doctor's expectations of good patient behavior [Mauksch, 1975]. Moreover, even when they are willing to risk bothering their physicians with questions, such patients are usually convinced that their vocabularies are inadequate for the job. They are often too intimidated by even slightly technical jargon to request more information than their doctors proffer.

Just as such patients are hesitant to speak to their doctors because they are unfamiliar with medical
terminology, so too are NESPs unfamiliar with even the basic English that would allow them to ask a simple question and understand the response. As most of the "silent" NESPs explained, they did not talk to their caregivers because they could not speak English. And if, as Waitzkin has suggested, the physicians and nurses caring for NESPs had little expectation that their patients would ask questions -- whether as a result of previous experience with NESPs or other factors, the NESPs' reticence fulfilled that expectation and reinforced the assumptions underlying it.

The poor correlation between the means used by physicians and nurses to communicate with their NESPs and the patients' knowledge of their conditions and treatment is at least partially accounted for by Waitzkin's explanation that patients typically get little information from the caregiver who expects no questions. Thus even some of the staff who spoke Spanish or used an interpreter may not have given their NESPs much substantial information, despite their ability to provide it, because they believed that the patients neither wanted or needed it.

The NESPs, for their part, had expectations that reinforced this pattern of silence. Most had been in the United States long enough to know that to leave their Spanish-speaking enclaves entailed linguistic isolation. Therefore it is highly likely that the NESPs never anticipated that their caregivers would speak to them in
anything but simplistic English, as that is the way in which North Americans typically deal with people who speak another language. As noted in Chapter 2, 70% of the NESP had been hospitalized in the United States previously, 26% in the study hospital[^20]; many undoubtedly learned from those experiences that doctors and nurses do not talk to patients who cannot speak English.

A fundamental assumption of the literature on communication and satisfaction is that satisfaction cannot be defined apart from expectations [Korsch, Gozzi, & Francis, 1968; Larsen & Rootman, 1976; Linder-Pelz, 1983; Murphey-Cullen & Larsen, 1984; Segall & Burnett; 1980]. Susie Linder-Pelz has concluded that differing expectations consistently explain most variations in patients' reported satisfaction with their physicians [Linder-Pelz, 1983]. The NESP's limited expectations would easily account for their satisfaction with even the worst possible communication.

While the typical ESP, like patients in most studies, seemed to expect some degree of communication with caregivers and was satisfied with care only to the extent that good communication took place, the NESP appeared to expect little or no such communication. Consequently they seemed satisfied with none and were delighted when the Spanish-speaking interpreters provided anything more.

The suggestion that patients rely on their assessments of communication when they cannot judge technical skill
takes a unique twist in the case of the NESP's which may
account for their reported satisfaction with the service-
oriented features of care. It is likely that because these
patients expected little communication with their
caregivers, they gave more weight to such other factors as
comfort and prompt "service". In a number of instances,
caregivers who scored high in these areas were also judged
to be good communicators, despite the patients' poor
understanding.

Moreover, the conclusions of F. Ross Woolley and his
associates also seem to apply to the NESP's reported
satisfaction; their caregivers' actual success at
communicating information was less important than the effort
that they made [Woolley et al., 1978]. Several NESP's who
seldom talked with their caregivers and understood little of
what they said were nonetheless extremely pleased that their
doctors asked whether they had any questions. Such behavior
may be the "attentiveness" that a number of patients
praised, and the NESP's positive response may reflect the
value of the human presence that communication affords.
This preference may also explain why a few patients reported
greater satisfaction with caregivers whom they could not
understand than with a few who did speak Spanish.

One final indication that good communication is
important to NESP's is their evaluation of their overall
hospital care. In their assessments of the hospitals'
services in general, there was a distinct and statistically 
significant difference between the reported satisfaction of 
the NESPs and that of the ESPs (p<.01). Although all but 2 
of the NESPs reported that they were satisfied with the 
hospital, only 30% claimed to be very satisfied, compared to 
83% of the ESPs [See Table 45].

Table 45. "Are you satisfied with the hospital in general?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=23</td>
<td>N=23</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>7 (30%)</td>
<td>19 (83%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>14 (61%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>2 (9%)</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Although a correlation between the patients' satisfaction with the hospital and the quality of their communication with their caregivers is clearly demonstrated here, this correlation can only suggest that NESPs' satisfaction may be influenced by factors of communication; it remains unclear what place communication has in NESPs' evaluation of their health care. Before health care professionals can determine how best to deal with patients who speak no English, more information must be obtained about their expectations and the motives, conscious or unconscious, behind their communication behavior. It must be determined, first of all, whether all patients truly want
the same type of communication with their physicians, as the literature suggests. If the studies that have reached these conclusions are indeed heavily weighted toward Anglo values, other demographic variables notwithstanding, the research on satisfaction must be extended into minority communities and a broader mix of cultures represented.

Applying the findings of such social science research to improve the actual practice of medicine is a constant challenge. To develop and teach communication skills that can be used by caregivers in any setting should be a priority among social scientists, ethicists, and health care professionals themselves. However, even if it proves accurate to say that all patients want the same kind of communication, it is vital to remember that each patient has individual needs which transcend the common findings of social science. Even if it is possible to identify the kind of communication and information that Hispanic NESPs typically want from their doctors, there is no typical Hispanic NESP, and there can be no set formula for communicating with all such patients.

Working with patients who, like many of the NESPs, deny the need for medical information, raises special ethical problems which are seldom addressed. Patients who accept care without question or refuse information about their conditions shift much of the burden of illness onto their caregivers. The extent to which caregivers of all types
should encourage patients to participate actively in their own care, and how to teach them to take responsibility for their own health and lives, is a question of vigorous public and professional debate. Clearly, many doctors, nurses, and others are still willing to assume responsibility for their patients even to the point where the patients themselves are little more than passive observers of their own treatment.

The degree to which health care professionals should assume such responsibility for others, and the amount of information that the patient can absorb and use, can be determined only on an individual basis. Effective communication is essential to making that determination, and to providing the requisite information and support afterward. The subject of such communication in shared responsibility will be explored in detail in the final chapter.

Notes to Chapter 3

1. The patient who claimed not to have been seen by any doctors was not interviewed about physicians, although her chart indicated that a resident had seen her on several occasions.

2. Most of the NESP's who reported that their family members translated for them were accompanied by those relatives during the interviews. Often, and for unknown reasons, the relatives tried to talk with me in English; in almost every case their vocabulary was limited and in several cases they too admitted that they did not understand the staff very well.
when their patient would be well enough to go home, with the exception of 2 who were awaiting test results.

12. Each patient had a minimum of 3 nurses — 1 per shift. Most had considerably more, as nursing assignments could change daily.

13. In at least 3 cases the Spanish-speaking "nurse" was probably a female resident.

14. Three patients did not answer the question, explaining that they had no appropriate answer because they did not talk to their nurses.

15. Because of the small numbers of patients interviewed on ancillary care, their evaluations are presented in 3 sets of tables which pair allied health and social service professions according to the nature, duration, and focus of their interaction with patients. Therapists and dieticians are combined as they are involved with patients in limited, therapeutic contexts, and their encounters center on specific instructions or questions. Social workers and chaplains are combined because their interaction with patients is more open ended and may involve counseling and discussion of nonmedical problems. Patient representatives, interpreters, and volunteers are combined because, with the exception of 3 unidentified translators, all are members of the patient representative staff.

16. Unfortunately, while this first patient gave a perfect description of the chaplain in question, his comments are suspect because the chaplain speaks no Spanish, and admitted being unable to understand what the patient had said during their visit. It is likely that the patient misperceived their encounter under the influence of the pain medication prescribed for his serious injury. The others' responses were undoubtedly influenced by their substantial hospital experience. The first patient suffered from chronic asthma and had undergone similar breathing treatments many times before; the basic words that the therapists used were probably sufficient to convey familiar instructions, and she would have had few questions about the procedure. The second had been hospitalized recently a number of times and had been seen by that dietician on earlier admissions. Because she was familiar with his condition and preferences, she would have been able to gather the information necessary for an updated assessment in fairly simple language.

17. The official interpreters denied having seen any of
3. Those patients who are listed under "little" commented spontaneously that their communication was limited to just "a little".

4. "Other" in this context and wherever used in similar tables refers to vague or non sequitur responses such as "I don't know", "Because it's true", "I just feel that way", etc.

5. This patient was a trauma victim, however, and it was clear to him both what was wrong and that his condition was responding to treatment.

6. The accuracy of patients' descriptions of their diagnoses and treatment was not measured in terms of their use of jargon or medical terminology, but rather by their ability to explain the source of their conditions and what the diagnoses meant.

7. This group includes those who were referred to the hospital by a private doctor or clinic, and those who had been diagnosed and treated elsewhere earlier for the same problem, but came in through the emergency room without a referral.

8. This patient insisted that his doctors had cured his "ulcer" despite the presence of abdominal and pulmonary metastases. He suffered a respiratory arrest 2 days after the interview and died. His claim of good health may have been the result of a number of things, including denial, poor communication with the staff due to the language barrier, incomplete or false information about his disease from his doctors, nurses, or family members, or a combination of these factors. Crowther's unpublished dissertation on the care of the terminally ill discusses in some detail the communication problems of NESPs dying in hospitals and hospices [Crowther, 1975].


10. Answers were assessed for matches according to the following scale:
    - Matches well = within 1 day
    - Matches somewhat = within 2-3 days
    - Matches poorly = within 4-6 days
    - Does not match = +/- 7 days

11. All of the physicians interviewed (usually within 24 hours of the patient's interview) knew approximately
these 3 patients. It is possible that these persons -- all female -- were nurses or medical personnel, but they could not be traced, despite repeated attempts.

18. The majority of the research done in the U.S. has been done in the north and northwest, where Hispanics may be poorly represented in the patient population.

19. A few of the female NESP's and 1 female ESP on Medicaid seemed to be particularly aware of the elevated status of the nurses. More than one NESP commented that the nurses were pretty, clean, or neatly dressed, with the clear implication that this professional appearance was worthy of their respect.

20. These figures are adjusted to reflect only the NESP's from the matched population.
Chapter 4

Staff Views on Communication with NESPs

The patient interviews on communication with hospital personnel were complemented by a series of interviews with staff members involved in their care. These staff interviews were designed to answer two broad questions: how hospital personnel react to working with NESPs in general, and how their perceptions of their interaction with NESPs compare to those of the patients.

Interview Population and Methods

The staff interview was much shorter than the patient questionnaire. Nine questions addressed the staff member's general professional experience with NESPs. Ten questions referred specifically to the respondent's interaction with a given patient enrolled in the study, four of which were introductory questions included to ensure that the staff member knew the patient and could answer accurately [A copy of the staff interview appears as Appendix III].

One hundred thirty medical, nursing, allied health and social service personnel were interviewed about their patients enrolled in the study; 125 members of this group responded to the questions on professional experience with NESPs. The staff members interviewed represented 10 professional categories: 1) attending physician, 2) resident physician, 3) medical student, 4) nurse, 5) therapist,
6) dietician, 7) social worker, 8) chaplain, 9) patient representative/interpreter, and 10) volunteer. At least 2 staff members were interviewed per patient, chosen from the personnel whom the patient had reported seeing. In all but a few cases, at least one doctor and one nurse were interviewed for each patient; allied health and social service personnel were interviewed where reported.

As most patients could not name the individuals caring for them and were unable to distinguish among the medical personnel, identifying the appropriate staff members to interview was sometimes difficult. When the patient knew the attending physician's name and could distinguish him or her from the residents, medical students, and nurses, the attending physician was contacted for an interview. The small number of attendings interviewed reflects their poor recognition by patients, the sizeable percentage of clinic patients who were cared for almost exclusively by residents, and difficulty in gaining access to the attendings for an interview.

Residents' and medical students' names were obtained from, or verified by, the patients' charts. Wherever possible, patients' physical descriptions of their doctors were used to select among those eligible for interviewing. In most cases, the first-year resident (intern) had primary responsibility for patient care, and was sought out first. If the intern was unavailable or unwilling to participate,
a senior resident or medical student was contacted.

Generally, the nurses who were interviewed were those on duty at the time that their patients were contacted. Patient interviews were conducted between 9 AM and 8 PM, seven days a week, and nurses from the morning, evening, and weekend shifts were included in the staff survey; night shift nurses were not sought out. Both registered nurses (RNs) and licensed vocational nurses (LVNs) were interviewed as their basic patient care duties were similar and patients did not distinguish between their positions.

Therapists, dieticians, and social workers were seldom identified by their patients. Their names were also taken from the patients' charts. The names of chaplains, patient representatives/interpreters, and volunteers, who do not make chart notes, were obtained through their respective offices when their patients could not identify them.\(^3\) Patients' physical descriptions of these personnel were also matched to the potential respondents. A few respiratory therapists and chaplains who were identified or described by their patients were not interviewed because they did not recall the patients in question.

Some personnel were automatically excluded from the survey based on comments from the patients' interviews. Residents and medical students who were part of a given patients' medical team were not eligible if the patient reported there to have been no direct contact between them
apart from group rounds. This exclusion limited the eligible medical personnel for each patient to 3-4 persons. In addition, patients were asked to describe their typical interactions with members of each profession as a group whenever they were cared for by more than one person in the same role. At the end of each section of the interview, patients were asked whether all of the members of that group fit the general description that they had just given, and if not, who that person was and why he or she was different. In order to ensure that the patient's and staff member's respective perceptions could be compared fairly, any caregiver cited as atypical was not contacted. However, patients reported a remarkable consistency in the behavior of the staff, and few persons were excluded in this way.

Similar behavior among personnel within each category permitted some latitude in selecting whom to interview in cases where staff members had already been interviewed in connection with another patient. Nonetheless, because many of the staff cared for a number of the patients enrolled in the study, some persons had to be interviewed about their work with more than one patient. Still others refused to be interviewed more than once. The comparably small number of staff members surveyed reflects these problems.

Because the staff survey was conceived as a supplement to the patient interviews, and for practical reasons needed to be quite brief, no demographic information was obtained
on staff respondents. However, the staff questionnaire is intended only to give indications of the general experience and sentiment of the staff caring for patients enrolled in the study, and to serve as a backdrop to the patients' perceptions and experience in the hospital.

Staff Reactions to Caring for Non-English Speaking Patients

The primary goal of this part of the study was to discover how the staff felt about caring for NESP s, and whether they recognized any difference in the treatment which NESP s and ESP s received that might be attributable to a language barrier. The presence of such a barrier was readily apparent: of the 125 staff members surveyed, 79 (64%) claimed that they knew "a few words" of Spanish, and 21 (17%) said that they could speak no Spanish at all [See Table 46]. Only 25 (20%) reported that they could speak Spanish either "fluently" or "somewhat".4

The percentage of Spanish-speaking personnel reported here is probably higher than that of the hospital staff as a whole, as the study specifically included the 5 patient representative/interpreters (20% of the Spanish speakers), whose job requires that they speak Spanish fluently. Moreover, the staff's self-assessments may be somewhat inflated; as described in a later section, Spanish-speaking patients tended to give their caregivers' abilities much lower ratings.* More representative of the staff in general, and more important for everyday care, are the
responses of the residents, medical students, and nurses: 81% of the residents and medical students and 89% of the nurses claimed to speak no Spanish or know only a few words.

Table 46. "Do you speak Spanish?"

<table>
<thead>
<tr>
<th>Position</th>
<th>Fluently</th>
<th>Somewhat</th>
<th>Few words</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>1 (14%)</td>
<td>1 (14%)</td>
<td>5 (71%)</td>
<td>--</td>
</tr>
<tr>
<td>Residents/ Med Students</td>
<td>4 (8%)</td>
<td>5 (10%)</td>
<td>32 (67%)</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>3 (5%)</td>
<td>3 (5%)</td>
<td>37 (66%)</td>
<td>18 (23%)</td>
</tr>
<tr>
<td>Therapists/ Dieticians</td>
<td>1 (33%)</td>
<td>--</td>
<td>2 (67%)</td>
<td>--</td>
</tr>
<tr>
<td>Chaplains/ Social Workers</td>
<td>--</td>
<td>2 (40%)</td>
<td>3 (60%)</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/ Interpreters</td>
<td>5 (100%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14 (11%)</strong></td>
<td><strong>11 (9%)</strong></td>
<td><strong>79 (63%)</strong></td>
<td><strong>21 (17%)</strong></td>
</tr>
</tbody>
</table>

Both the staff caring for NESPs enrolled in the study (NESP staff) and those caring for ESPs (ESP staff) were asked how they communicated with patients who did not speak English. The NESP staff referred to their interaction with the specific NESPs in the study, while the ESP staff described their encounters with NESPs in general. One remarkable difference between the ESP staff and NESP staff was a two-fold difference in the number of personnel who claimed to use interpreters [See Table 47]. The non-Spanish speaking ESP staff reported almost unanimously that they
<table>
<thead>
<tr>
<th>Position</th>
<th>Sentences in Spanish</th>
<th>Sentences in English</th>
<th>Simple words in Spanish</th>
<th>Simple words in English</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NESP / ESP</td>
<td>NESP / ESP</td>
<td>NESP / ESP</td>
<td>NESP / ESP</td>
</tr>
<tr>
<td>Attendings N=4/5</td>
<td>2 (50%)</td>
<td>--</td>
<td>1 (25%)</td>
<td>1 (25%)</td>
</tr>
<tr>
<td>Residents/ Med Students N=24/30</td>
<td>4 (17%)</td>
<td>1 (4%)</td>
<td>12 (50%)</td>
<td>12 (50%)</td>
</tr>
<tr>
<td>Nurses N=24/35</td>
<td>2 (17%)</td>
<td>1 (6%)</td>
<td>15 (63%)</td>
<td>15 (63%)</td>
</tr>
<tr>
<td>Therapists/ Dieticians N=2/4</td>
<td>--</td>
<td>1 (25%)</td>
<td>2 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>Chaplains/ Social Workers N=2/4</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/ Interpreters N=5/0</td>
<td>5 (100%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Total N=61/78</td>
<td>13 (21%)</td>
<td>5 (6%)</td>
<td>28 (46%)</td>
<td>28 (36%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
N=NESP staff/ESP staff
Table continued on next page.
Table 47. "How do you try to communicate with your NESP(s)?" - continued

<table>
<thead>
<tr>
<th>Position</th>
<th>Via translator</th>
<th></th>
<th></th>
<th>Other patient-other visitor</th>
<th>Interpreter-staff member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NESP</td>
<td>ESP</td>
<td>NESP</td>
<td>ESP</td>
<td>NESP</td>
</tr>
<tr>
<td>Attendings</td>
<td>2 (50%)</td>
<td>5 (100%)</td>
<td>2 (50%)</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td>N=4/5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents/Med Students</td>
<td>13 (54%)</td>
<td>27 (90%)</td>
<td>4 (17%)</td>
<td>5 (17%)</td>
<td>3 (13%)</td>
</tr>
<tr>
<td>N=24/30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>8 (33%)</td>
<td>27 (77%)</td>
<td>3 (13%)</td>
<td>4 (11%)</td>
<td>3 (13%)</td>
</tr>
<tr>
<td>N=24/35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists/Dieticians</td>
<td>1 (50%)</td>
<td>3 (75%)</td>
<td>1 (50%)</td>
<td>2 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>N=2/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplains/Social Workers</td>
<td>1 (50%)</td>
<td>3 (75%)</td>
<td>--</td>
<td>1 (25%)</td>
<td>--</td>
</tr>
<tr>
<td>N=2/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>N=5/0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25 (41%)</td>
<td>65 (83%)</td>
<td>10 (16%)</td>
<td>13 (17%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>N=61/78</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
N=NEESP staff/ESP staff
communicated with their NESPs through a translator: all 5 (100%) of the attendings, 27 (96%) of the residents and medical students, 27 (82%) of the nurses, and 6 (75%) of the ancillary personnel indicated that they used translators when they needed to speak to their NESPs. Many claimed that they almost always used an official interpreter or a member of the medical or nursing staff for their translation.

However, the staff members caring for NESPs enrolled in the study indicated that they were much less likely to call for translation. Only 8 (36%) of the nurses and 13 (65%) of the residents and medical students reported that they used interpreters. In at least half of the cases the translator whom they used was not an official hospital interpreter or member or the staff, but one of the patients' family members or another patient; several personnel admitted using whomever was most convenient.

It seems likely that the responses of the staff working with specific NESPs at the time of the interview would provide a more accurate description of the use of interpreters, inasmuch as their experience was much more immediate. Moreover, many staff members from both groups indicated that they used interpreters only for "important" communication if someone who spoke Spanish was not immediately available. Coupled with later staff comments that others were often unwilling to make the effort to find an interpreter, and the official interpreters complaints
that they were called too infrequently [See Table 52], this discrepancy suggests that many staff members ignored the language barrier or worked around it in other ways.

Among both the staff who used interpreters and those who did not, many reported that they relied on simple words in English, simple words in Spanish, and gestures to ask questions and get their points across. The most common form of communication from staff person to patient at every level of care was simple words which the staff believed that the patients would recognize7. The words mentioned most frequently among medical and nursing staff were "pain" and its Spanish equivalent "dolor" (often mispronounced "dol-or-ay"). Many nurses suggested that gestures were an effective means of communicating some instructions or requests even when no words were used.

The picture that emerges from these responses portrays the staff member as able to say very little of any significance to the NESP, who is similarly unable to provide the staff with much useful feedback. Simple words and gestures can convey only simple ideas, and the complexities of the greater part of medical interaction remain beyond the scope of such efforts. This depiction of the staff cut off from their patients who speak no English complements the image of the linguistically isolated NESP outlined by the patient interviews, and demonstrates that the mutual inability to speak the other's language is a formidable
obstacle to medical communication.

The effects of a language barrier on the work of individual caregivers are clearly seen in the sentiment expressed by 76 (61%) of the staff members that they were not able to give their best care to patients who did not speak English [See Table 48]. The great majority (92%) of this group spoke little or no Spanish, but it also included 6 persons (1 attending physician, 3 residents, 1 social worker, and 1 chaplain) who were able to speak Spanish fluently or "somewhat". If the data is adjusted to measure only those who do not speak Spanish, the percentage of staff members who felt that they could not give their best care to NESP jumps to 70%.

Table 48. "Do you feel that you are able to give your best care to patients who don't speak English?"

<table>
<thead>
<tr>
<th>Position</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>3 (42%)</td>
<td>4 (57%)</td>
</tr>
<tr>
<td>Residents/Med Students</td>
<td>13 (27%)</td>
<td>35 (73%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>25 (45%)</td>
<td>31 (55%)</td>
</tr>
<tr>
<td>Therapists/Dieticians</td>
<td>2 (100%)</td>
<td>--</td>
</tr>
<tr>
<td>Chaplains/Social Workers</td>
<td>--</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>5 (100%)</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>49 (39%)</td>
<td>76 (61%)</td>
</tr>
</tbody>
</table>
The primary reasons given for the caregivers' reported impairment was the language barrier and subsequent problems resulting from poor communication; 25 (33%) of the 76 cited an inability to communicate as the reason that they could not provide their best care to NESP's [See Table 49]. The inability of staff members to talk to NESP's, to explain procedures, give instructions, teach self-care or prevention, or reassure NESP's about treatment was cited by 31 (41%) of the 76 caregivers as central to the problem of compromised care. Just as important, 29 respondents (38%) attributed the difficulty to the patient's inability to express needs and ask questions of caregivers who cannot understand his or her language.

Thirteen staff members (17%) found that it was difficult or inconvenient to arrange for the interpreting which could overcome the communication gap, and 14 (18%) were concerned that, even when they worked with a translator, something was always lost in the translation. Ten (13%) concluded that caring for NESP's took longer and required more effort than working with patients who could speak English.

The frequency of specific responses among the staff members of different positions reflects the perceived emphases of the respective professions. Physicians were most aware of the patient's inability to express their needs, especially as it affected the reporting of symptoms
Table 49. "Why do you say that you can't give your best care to NESPs?"

<table>
<thead>
<tr>
<th>Position</th>
<th>Language barrier</th>
<th>Can't teach or explain</th>
<th>Can't ask questions</th>
<th>Pt can't complain</th>
<th>Can't get interpreter</th>
<th>Data lost in translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>2 (50%)</td>
<td>2 (50%)</td>
<td>--</td>
<td>1 (25%)</td>
<td>1 (25%)</td>
<td>--</td>
</tr>
<tr>
<td>Residents Med Students</td>
<td>11 (31%)</td>
<td>9 (26%)</td>
<td>9 (26%)</td>
<td>17 (49%)</td>
<td>5 (14%)</td>
<td>9 (26%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>9 (29%)</td>
<td>21 (68%)</td>
<td>--</td>
<td>9 (29%)</td>
<td>6 (19%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Therapists/Dieticians</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Chaplains/Social Workers</td>
<td>3 (60%)</td>
<td>--</td>
<td>--</td>
<td>2 (40%)</td>
<td>1 (20%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25 (33%)</strong></td>
<td><strong>31 (41%)</strong></td>
<td><strong>9 (12%)</strong></td>
<td><strong>29 (38%)</strong></td>
<td><strong>13 (17%)</strong></td>
<td><strong>14 (18%)</strong></td>
</tr>
</tbody>
</table>

N=76

Percentages total more than 100% due to multiple responses.

Table continued on next page.
Table 49. "Why do you say that you can't give your best care to NESPs?" - continued

<table>
<thead>
<tr>
<th>Position</th>
<th>More work-takes longer</th>
<th>No informal conversation</th>
<th>Might miss something</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Residents/ Med Students</td>
<td>2 (6%)</td>
<td>4 (11%)</td>
<td>4 (11%)</td>
<td>10 (29%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>8 (26%)</td>
<td>3 (10%)</td>
<td>--</td>
<td>11 (35%)</td>
</tr>
<tr>
<td>Therapists/ Dieticians</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Chaplains/ Social Workers</td>
<td>--</td>
<td>2 (40%)</td>
<td>--</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Patient Reps/ Interpreters</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10 (13%)</strong></td>
<td><strong>9 (12%)</strong></td>
<td><strong>4 (5%)</strong></td>
<td><strong>26 (34%)</strong></td>
</tr>
<tr>
<td><strong>N=76</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
and history. Nurses were most concerned about their difficulty in giving instructions and explanations to patients, and their inability to teach self-care. Among the dieticians, chaplains, and social workers, whose duties often require prolonged conversation, there was frustration that translated dialogue was never as complete as direct conversation, and that important details and sentiments were always lost.

Of the 49 staff members who answered that they could give their best care to NESPs, 19 (39%) were able to speak Spanish; 12 of the 19 believed that it was their ability to speak Spanish that allowed them to give their best care to NESPs [See Table 50]. Another 9 (18%) indicated that they were able to give their best care because they used an interpreter whenever they needed to communicate with patients who spoke no English. Eight others (16%) maintained that they tried harder and spent more time with NESPs to make up for other deficiencies.

However, 13 (27%) of these 49 staff members expressed the belief that adequate communication is always possible, even when the patient and caregiver do not speak the same language. Many cited gesture and demonstration as an adequate means of communicating nonverbally, and several indicated that shared goals and good will made mutual understanding possible where verbal communication was impossible. An additional 15 (31%) replied that care did
Table 50. "Why do you say that you can give your best care to NESPs?"

<table>
<thead>
<tr>
<th>Position</th>
<th>Speak Spanish</th>
<th>Use a translator</th>
<th>Communicate other ways</th>
<th>Try harder -spend time</th>
<th>No difference -not important</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>1 (33%)</td>
<td>1 (33%)</td>
<td>--</td>
<td>--</td>
<td>1 (33%)</td>
<td>2 (67%)</td>
</tr>
<tr>
<td>Residents/ Med Students</td>
<td>5 (38%)</td>
<td>1 (8%)</td>
<td>2 (15%)</td>
<td>5 (38%)</td>
<td>7 (54%)</td>
<td>2 (15%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>1 (4%)</td>
<td>7 (28%)</td>
<td>9 (36%)</td>
<td>2 (8%)</td>
<td>12 (48%)</td>
<td>4 (16%)</td>
</tr>
<tr>
<td>Therapists/ Dieticians</td>
<td>1 (33%)</td>
<td>--</td>
<td>2 (67%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Chaplains/ Social Workers</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/ Interpreters</td>
<td>5 (100%)</td>
<td>--</td>
<td>--</td>
<td>1 (20%)</td>
<td>--</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Total</td>
<td>13 (27%)</td>
<td>9 (18%)</td>
<td>13 (27%)</td>
<td>8 (20%)</td>
<td>20 (41%)</td>
<td>11 (22%)</td>
</tr>
</tbody>
</table>

N=49

Percentages total more than 100% due to multiple responses.
not differ with language, and that all patients received the same care regardless of the staff member's ability to communicate with them.

It is of particular interest to note that the nurses, who spend by far the most time with patients, were the most likely to respond that their level of care did not vary with the patient's ability to speak English. Of the 56 nurses surveyed, 25 (45%) suggested that they could always give their best care to NESPs. Of these 25, 6 (24%) claimed that they were able to do so because they spoke Spanish, and 7 (28%) claimed to rely on translators for important communication. Yet 10 (40%) stated that nursing care did not differ with a patient's language, and 11 (44%) held that communication was always possible through means other than language.

Not only did many individual staff members believe that their individual caregiving abilities were impaired when their patient was unable to speak English, the majority also considered the overall care given to most NESPs to be inferior to that given to most ESPs. Of the 125 staff members questioned, 55 (44%) stated that the general care that NESPs received was the same as the care given to ESPs, while 63 (50%) were of the opinion that it was somewhat worse, and 4 (3%) found it to be significantly worse; only 1 person believed NESPs' overall treatment to be somewhat better than that of ESPs [See Table 51].
Table 51. "How would you rate the total care given to NESP interventions, compared to the care given to ESPs?"

<table>
<thead>
<tr>
<th>Position</th>
<th>Somewhat Better</th>
<th>Same</th>
<th>Somewhat Worse</th>
<th>Much Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>--</td>
<td>--</td>
<td>7 (86%)</td>
<td>--</td>
</tr>
<tr>
<td>Residents/Med Students</td>
<td>--</td>
<td>26 (54%)</td>
<td>20 (42%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>1 (2%)</td>
<td>26 (46%)</td>
<td>26 (46%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Therapists/Dieticians</td>
<td>--</td>
<td>--</td>
<td>4 (100%)</td>
<td>--</td>
</tr>
<tr>
<td>Chaplains/Social Workers</td>
<td>--</td>
<td>--</td>
<td>3 (100%)</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>--</td>
<td>1 (20%)</td>
<td>4 (80%)</td>
<td>--</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1 (1%)</strong></td>
<td><strong>55 (44%)</strong></td>
<td><strong>63 (50%)</strong></td>
<td><strong>4 (3%)</strong></td>
</tr>
</tbody>
</table>

The most common reason given for finding that NESP interventions and ESPs receive the same care was the belief that treatment in general is not dependent upon communication or that language barriers pose no threat to quality of care. Surprisingly, this position was taken by 36 staff members, 65% of the group that found no difference in care [See Table 52]. This is almost twice the number of staff members who gave a similar answer in the previous question about their own, individual ability to care for NESP interventions; although they expressed doubts about their own skills, these respondents were uncritical of the system as a whole. Residents and medical students and nurses were the most likely to reply
Table 52. "Why do you say that NESPs get the same care, in general, as ESPs?"

<table>
<thead>
<tr>
<th>Position</th>
<th>Treatment not dependent on communication</th>
<th>Translation available</th>
<th>Staff spends time</th>
<th>Communication always possible</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Residents/ Med Students</td>
<td>19 (73%)</td>
<td>8 (31%)</td>
<td>6 (23%)</td>
<td>1 (4%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>15 (58%)</td>
<td>10 (38%)</td>
<td>2 (12%)</td>
<td>2 (8%)</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>Therapists/ Dieticians</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Chaplains/ Social Workers</td>
<td>2 (100%)</td>
<td>1 (50%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/ Interpreters</td>
<td>--</td>
<td>--</td>
<td>1 (100%)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Total N=55</td>
<td>36 (65%)</td>
<td>19 (35%)</td>
<td>10 (18%)</td>
<td>3 (5%)</td>
<td>4 (7%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
that language barriers affected neither their own work with
NESPs nor NESPs' overall care. Here 19 residents (73%) and
15 nurses (58%) stated that quality of care was ultimately
independent of communication. Many of these residents
expressed the opinion that "medical treatment is medical
treatment", while many of the nurses claimed that "a patient
is a patient".

The availability and use of translation for NESPs was
cited as a second reason that their care was equal to that
of ESPs. Nineteen staff members (35%), including 8 (31%)
residents and medical students and 10 (38%) nurses, found
that translation, in some cases if only for important
communication, made care the same among all patients.

Ten caregivers (18%) believed that the staff spent
more time with NESPs and did more for them, making up for
any possible differences. This opinion was expressed by 6
(23%) residents and medical students, and by 3 (12%) nurses.
One volunteer interpreter believed that the extra attention
given to NESPs by the patient representatives compensated
for poor communication with the rest of the staff.

Sixty-seven staff members, 53% of the 125 interviewed,
however, believed that the care that NESPs receive is
generally worse than that given to ESPs [See Table 53]. The
language barrier and subsequent overall difficulties in
communication were cited as the cause of this gap by 19
(28%) staff members.
Table 53. "Why do you say that NESPs get worse care, in general, than ESPs?"

<table>
<thead>
<tr>
<th>Position</th>
<th>Language barrier</th>
<th>Can't teach or explain</th>
<th>Can't ask questions</th>
<th>Pt can't complain</th>
<th>Can't get interpreter</th>
<th>Staff avoids them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>5 (83%)</td>
<td>1 (16%)</td>
<td>--</td>
<td>3 (50%)</td>
<td>2 (33%)</td>
<td>1 (16%)</td>
</tr>
<tr>
<td>Residents/ Med Students</td>
<td>9 (41%)</td>
<td>6 (27%)</td>
<td>5 (23%)</td>
<td>13 (59%)</td>
<td>2 (9%)</td>
<td>8 (36%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>4 (14%)</td>
<td>7 (25%)</td>
<td>--</td>
<td>10 (36%)</td>
<td>11 (39%)</td>
<td>8 (29%)</td>
</tr>
<tr>
<td>Therapists/ Dieticians</td>
<td>--</td>
<td>1 (25%)</td>
<td>--</td>
<td>1 (25%)</td>
<td>1 (25%)</td>
<td>4 (100%)</td>
</tr>
<tr>
<td>Chaplains</td>
<td>--</td>
<td>1 (33%)</td>
<td>1 (33%)</td>
<td>--</td>
<td>--</td>
<td>2 (67%)</td>
</tr>
<tr>
<td>Social Workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Reps/ Interpreters</td>
<td>1 (25%)</td>
<td>3 (75%)</td>
<td>1 (25%)</td>
<td>1 (25%)</td>
<td>--</td>
<td>4 (100%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19 (28%)</strong></td>
<td><strong>19 (28%)</strong></td>
<td><strong>7 (10%)</strong></td>
<td><strong>28 (42%)</strong></td>
<td><strong>16 (24%)</strong></td>
<td><strong>27 (40%)</strong></td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
Table continued on next page.
Table 53. "Why do you say that NESPs get worse care, in general, than ESPs?" - continued

<table>
<thead>
<tr>
<th>Position</th>
<th>More work-takes longer</th>
<th>No informal conversation</th>
<th>Data lost in translation</th>
<th>NESPs more anxious</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>--</td>
<td>--</td>
<td>2 (33%)</td>
<td>--</td>
<td>2 (33%)</td>
</tr>
<tr>
<td>Residents/Med Students</td>
<td>3 (14%)</td>
<td>3 (14%)</td>
<td>2 (9%)</td>
<td>4 (18%)</td>
<td>16 (73%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>1 (4%)</td>
<td>4 (14%)</td>
<td>2 (7%)</td>
<td>1 (4%)</td>
<td>12 (43%)</td>
</tr>
<tr>
<td>Therapists/Dieticians</td>
<td>2 (50%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1 (25%)</td>
</tr>
<tr>
<td>Chaplains/Social Workers</td>
<td>1 (33%)</td>
<td>--</td>
<td>--</td>
<td>1 (33%)</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Total N=67</td>
<td>7 (10%)</td>
<td>7 (10%)</td>
<td>6 (9%)</td>
<td>6 (9%)</td>
<td>33 (50%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
Many respondents also cited more specific problems related to the inability to communicate. The staff's inability to explain or give directions to patients, or reassure them during treatment, was given as a cause of inequality of care by 19 (28%) caregivers, and their inability to ask NESPs for information noted by 7 (10%). The patient's inability to express personal needs or ask questions was recognized as a contributing factor by 28 (42%) staff members. Sixteen (24%) responded that the unavailability of interpreters contributed to the problem; the majority of these were nurses: 11 (39%) expressed concern that translation was hard or inconvenient to obtain.

Many staff members claimed that one of the effects of poor communication which leads to lesser care for NESPs was that the staff avoids or ignores them and that caregivers are unwilling to make the extra effort to give them the attention that they deserve. This sentiment was expressed by members of every staff position included in the study. All of the therapists, dieticians, and patient representatives/interpreters who found NESP care to be substandard recognized staff avoidance to be a problem. Eight (36%) of the residents and medical students, and 8 (29%) of the nurses also cited avoidance and reluctance to do the necessary extra work. Seven (10%) staff members cited the extra work required and the time that it took to care for NESPs as an additional factor.
With or without translation, 7 (10%) members of the staff regretted that informal conversation was not possible with NESP's, because it provided information and built the rapport which improved overall care. An additional 6 (9%) maintained that NESP's received worse care because, even where an interpreter was used, something was always lost in the translation.

A tendency for NESP's to be more anxious, afraid, or depressed was cited by 6 (9%) staff members. Residents and medical students in particular recognized that it was difficult to care for patients who could not understand what was happening and whom the staff could not easily reassure.

Irrespective of the quality of care that individual respondents believed NESP's to receive, 105 (84%) of 125 staff members interviewed believed that there were some particularly difficult aspects to caring for NESP's which were not present when working with ESP's [See Table 54]. Fifty (48%) of these respondents cited the problem of trying to deal with poor communication caused by the language barrier. Again, the specific issues of explaining treatment and giving instructions to patients (25%), asking patients for information (15%), and the patient's inability to express personal needs were noted (15%).

Recognizing and working with NESP's' different cultural backgrounds, both with respect to their understanding of disease and expectations of care, was considered by 20 (19%)
Table 54. "What do you feel is particularly difficult about caring for NESPs?"

<table>
<thead>
<tr>
<th>Position</th>
<th>Language barrier</th>
<th>Can't teach or explain</th>
<th>Can't ask questions</th>
<th>Pt can't complain</th>
<th>Cultural differences</th>
<th>Handling frustration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>2 (33%)</td>
<td>3 (50%)</td>
<td>--</td>
<td>1 (16%)</td>
<td>2 (33%)</td>
<td>--</td>
</tr>
<tr>
<td>Residents/Med Students</td>
<td>21 (40%)</td>
<td>8 (19%)</td>
<td>12 (29%)</td>
<td>3 (7%)</td>
<td>4 (10%)</td>
<td>5 (12%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>18 (41%)</td>
<td>15 (34%)</td>
<td>4 (9%)</td>
<td>9 (20%)</td>
<td>8 (18%)</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>Therapists/Dieticians</td>
<td>3 (100%)</td>
<td>--</td>
<td>--</td>
<td>1 (33%)</td>
<td>--</td>
<td>2 (67%)</td>
</tr>
<tr>
<td>Chaplains/Social Workers</td>
<td>3 (60%)</td>
<td>--</td>
<td>--</td>
<td>1 (20%)</td>
<td>3 (60%)</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>3 (60%)</td>
<td>--</td>
<td>--</td>
<td>1 (20%)</td>
<td>3 (60%)</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>50 (48%)</td>
<td>26 (25%)</td>
<td>16 (15%)</td>
<td>16 (15%)</td>
<td>20 (19%)</td>
<td>11 (10%)</td>
</tr>
</tbody>
</table>

N=105

Percentages total more than 100% due to multiple responses.
staff members to be quite difficult. Chaplains, social workers, and patient representative/interpreters, who work much less with patients' bodily ills and more with the nonphysical aspects of health care, were most conscious of this difficulty.

Among the staff members who dealt more extensively with physical care, handling frustration, primarily over the inability to communicate, was also recognized to be a particularly difficult aspect of treating NESPs. Five (12%) residents and medical students and 4 (9%) nurses responded that frustration over failure to communicate was a significant problem in their work with NESPs. One therapist and one dietician (67%) also experienced frustration as a difficult part of NESP care.

Of the 125 personnel surveyed, 16 (13%) used the specific word "frustrating" at some point in the interview to describe their interaction with NESPs or the reactions of their colleagues to caring for NESPs. Staff frustration with patients is itself an important indication that NESPs' care suffers. A patient with whom the staff become frustrated is often tagged as a "difficult" or "problem" patient, labels which may carry serious consequences for treatment [Anstett, 1980; Gorlin & Zucker, 1983; Hein, 1980; Lorber, 1979; Mauksch, 1975; Stockwell, 1972].

Physicians who become frustrated with given patients have been shown to respond to them with hostility,
rejection, and avoidance, and often a tendency to minimize the seriousness of their symptoms [Gorlin & Zucker, 1983; Gustafson, 1981; Stoeckle, 1987]. This reaction is particularly correlated with the patient's inability to understand explanations of his or her disease and its treatment, as occurs in the case of differences in language or cultural background, or the physician's overuse of technical terminology [Anstett, 1980; Gorlin & Zucker, 1983].

Nurses, like doctors, are prone to label patients who do not or cannot communicate easily with them as "problem" patients, and may reject and blame them for being difficult to work with [Harmuth et al., 1961; Stockwell, 1972]. Patients so labeled are often discriminated against by both their own nurses and their unit's entire staff. Such stereotyping has been linked to less attentive care, inaccurate nursing assessments, and inappropriate treatment based on those assessments [Bradley & Edinberg, 1982; Fritz et al., 1984; Hein, 1980; Stockwell, 1972].

Frustration is particularly insidious because most hospital staff are unconscious of its presence and unaware of its effects on their behavior [Gorlin & Zucker, 1983; Gustafson, 1981; Hein, 1980]. The fact that a number of staff members did recognize their frustration, and that several found NESPs' treatment to be substandard because the staff avoided or ignored them, indicates that frustration
with NESPs may be a very significant problem. Similarly, the comments made by several respondents that those caring for NESPs are often unwilling to make the effort to arrange for a translator to help give them quality care suggests that frustration may lead many to reject NESPs as neither needing nor deserving such attention.

The results of the general survey portion of the staff interviews reveal that there was some awareness among the hospital personnel that NESPs are different from their English-speaking counterparts, that interaction with them was complicated by the language barrier, and that their care was affected by poor communication. Yet the staff was conflicted about the scope and effects of this limited communication. While most acknowledged that their own professional abilities were hampered by poor communication, many insisted that what little communication was possible was still sufficient for adequate care, and recognized no difference between the treatment rendered to ESPs and NESPs.

The extent of this ambivalence is even more evident in the NESP staff's reported perceptions of their interactions with individual patients. This portion of the study reveals that most believed that they were effective in communicating with NESPs, and that many thought that their NESPs had adequate opportunity to discuss their care with staff members. By comparing the perceptions of the staff and their patients however, it becomes evident that the majority
of the staff were unaware of the extent to which their communication with NESPs was impaired, and how seriously their caregiving abilities were affected by the language barrier between them.

Comparing Staff and Patient Perceptions as an Indication of the Quality of their Communication

Comparisons between patients' and physicians' perceptions of their medical encounters have been used successfully to describe the quality of their communication for over 15 years in medical anthropological and sociological research. The primary models of communication employed in these studies define communication as an interactive process which establishes a "commonness" between two individuals [Lundberg et al., 1966]. The act of communicating requires that each party take on and alternate the roles of teller and hearer in a process of negotiation that ideally results in each putting him or herself in the place of the other and understanding the other's experiences and meaning. Thus, the quality of communication between two persons can be assessed by examining the degree of "commonness" created in their encounter.

Studies of doctor-patient communication based on this concept have demonstrated that where clear and thorough communication takes place, the patient and caregiver report similar perceptions of their interaction and a similar understanding of the information exchanged; conversely,
where there are discrepancies in their perceptions, patients tend to have a poor understanding of what was said and report unwillingness on the part of the caregiver to listen to or answer questions [Bain, 1976; Korsch & Negrete, 1972; Press, 1984; Waitzkin, 1985; Waitzkin & Stoeckle, 1976]. Similar research has demonstrated that physicians' perceptions of patient satisfaction with their doctors' behavior, including the quality of their communication, often differ substantially from patient reports [Biehn & Molineau, 1979; Merkel, 1984].

In most such research, communication is also quantified using Bales interaction process analysis, in which the encounter is recorded and transcribed, and the individual exchanges within the interview coded for affect and tallied [Bales, 1951]. Bales analysis is most often used to provide an objective background against which to measure the validity of subjective impressions about an encounter, and to determine what discrepancies exist between the parties' respective perceptions. Consistently patients have been found to assess key features of medical encounters more accurately than their physicians [Korsch & Negrete, 1972; Bain, 1976; Press, 1984; Waitzkin 1985; Waitzkin & Stoeckle, 1976]. One notable exception is patients' failure to recognize that the physician has explained something when the explanation is given in technical language.

Based on this body of research, the present study was
prepared with the hypothesis that discrepancies between the perceptions of staff members and patients would be greater among the NESPs and their caregivers than among the ESPs and theirs. No objective analysis of their interactions was undertaken, as the "commonness" created between them, measured by the similarity of their perceptions, was taken to be a reliable indication of the quality of staff-patient communication. In order to limit the effects of variables unrelated to the patient's proficiency in English, only the responses of the matched patient population and their caregivers were considered.

The questions in this section of the staff interview focused on the aspects of medical interaction where patients' and caregivers' perceptions are most likely to vary as a function of the quality of their communication: the length of their encounter [Korsch & Negrete, 1972; Waitzkin, 1985; Waitzkin & Stoekle, 1976]; the patient's understanding of the caregiver's comments and questions [Korsch & Negrete, 1972]; the caregiver's understanding of patient's comments and questions [Korsch & Negrete, 1972]; and the opportunity afforded to the patient for questions and discussion [Biehn & Molineux, 1979; Korsch & Negrete, 1972; Pratt, Seligmann & Reader, 1957; Waitzkin, 1985]. The frequency of caregiver visits was included as an additional issue raised by the study's hospital setting. NESPs' and their caregivers' judgments of the staff person's ability to
speak Spanish were also compared to assess the level of verbal communication possible between them.

The correlation between staff and patient perceptions, rather than the answers themselves, are reported in this section. While the wording of the questions varied slightly according to the role of the respondent, the fixed-alternative answers, coded numerically, were identical for patients and staff. The degree of correlation was determined by subtracting the number corresponding to the staff member's response from that of the patient. A positive figure indicates that the staff member perceived the communication in question to be better than the patient reported; a negative number indicates that the staff member perceived it to be worse. Where the result is zero, their perceptions were identical.

**Perceptions of medical personnel and their patients**

The interviews of 5 attending physicians, 15 residents, and 2 medical students were compared to those of their 46 NESP and ESPs. The attendings' responses were correlated with 3 of the 23 matched NESP and 2 of the 23 corresponding ESP; residents' answers were compared to those of 18 NESP and 22 ESP; medical students' responses were matched to those of 2 ESP.

Due to the small number of medical students included here, and because their patients believed them to be doctors, their correlations are reported with those of the
residents. However, although the number of attendings is too small to produce significant results, their correlations are presented separately because of the important trend that they indicate. In each case the patient knew the attending physician and reported confidence in the doctor as a person; the results of the correlation suggest that even where doctor and patient are well acquainted, a language barrier between them may cause them to have quite different perceptions of the same interaction.

Unlike the office setting where most doctor-patient communication studies take place, in the hospital the doctor comes to the patient. It was hypothesized that the physician's and patient's perceptions of the number of such visits might reflect the quality of their communication, in much the same way as do their perceptions of the visits' length. The results of this study do reveal a discrepancy between physicians' and patients' reports, although there is almost no difference between NESPs and ESPs on this point [See Table 55]. It is likely that part of the discrepancy is due to the common medical practice of visiting patients early in the morning when they may not be fully awake. Patients in both groups tended to note only those visits made later in the day. This trend may reflect the fact that many doctors see their patients only briefly in the early morning before rounds or surgery, primarily to check on their general progress overnight, and focus more on
physical examination than on conversation. However, it also suggests that early morning is not an ideal time for the doctor to ask the patient important questions or relate important information, as it may not be well understood or remembered.

Table 55. "How often does the doctor visit the patient?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESP (%)</th>
<th>ES (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+1</td>
<td>2 (67%)</td>
<td>--</td>
</tr>
<tr>
<td>0</td>
<td>1 (33%)</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Residents/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med Students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+3</td>
<td>--</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>+2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>+1</td>
<td>7 (39%)</td>
<td>6 (25%)</td>
</tr>
<tr>
<td>0</td>
<td>10 (56%)</td>
<td>13 (58%)</td>
</tr>
<tr>
<td>-1</td>
<td>1 (6%)</td>
<td>2 (8%)</td>
</tr>
</tbody>
</table>

The correlation between doctors' and patients' perceptions of the length of time that they spend together has been found to be a good indication of the quality of the communication between them, and there is frequently a considerable discrepancy between their reports. Doctors often overestimate the amount of time that they spend with their patients, both in the primary care setting and in the hospital, and misjudge the amount of time that they spend providing information during a visit [Korsch & Negrete, 1972; Press, 1984; Reynolds, 1978; Waitzkin, 1984; Waitzkin & Stoeckle, 1976]. Conversely, their patients' assessments are usually quite accurate [Korsch & Negrete, 1972; Press, 1984; Reynolds, 1978; Waitzkin & Stoeckle, 1976].
The results of the present survey are in keeping with the general finding that doctors and patients perceive the duration of their encounters differently, yet there is no clear trend in the way in which way their answers differ [See Table 56]. Among both groups of residents, the number whose answers matched those of their patients was smaller than the number whose answers were different, yet roughly equivalent percentages of physicians reported shorter visits as reported longer ones.

However, the difference between the perceptions of NESP s and their physicians is substantially greater than that between ESP s and their doctors: only 4 (22%) NESP-resident pairs reported that they spent the same amount of time together, compared to 10 (42%) of the ESP-resident pairs. Particularly remarkable in light of the suggestions of previous work in this area is that 8 (45%) of the residents caring for NESP s indicated that they spent less time with their patients than the patients reported, compared to 7 (29%) of the residents caring for ESP s. This particular discrepancy may be caused by NESP s' different cultural understanding of time or their expectations of doctors, or perhaps by the physicians' awareness and conscious discomfort of their inability to talk to their NESP s. This issue remains a subject for further exploration.

The correlations of the attending physicians and their
patients are more in keeping with what might be expected from the findings of other such studies. Two (67%) of the attendings report longer visits than their NESPs, while the 2 physicians caring for ESPs reported the same length or shorter visits than did their patients.

Table 56. "How much time does the doctor spend with the patient during a visit?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+2</td>
<td>1 (33%)</td>
<td>--</td>
</tr>
<tr>
<td>+1</td>
<td>1 (33%)</td>
<td>--</td>
</tr>
<tr>
<td>0</td>
<td>--</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>-1</td>
<td>1 (33%)</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Residents/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med Students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+2</td>
<td>1 (6%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>+1</td>
<td>5 (28%)</td>
<td>6 (25%)</td>
</tr>
<tr>
<td>0</td>
<td>4 (22%)</td>
<td>10 (42%)</td>
</tr>
<tr>
<td>-1</td>
<td>7 (39%)</td>
<td>7 (29%)</td>
</tr>
<tr>
<td>-2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>-3</td>
<td>1 (6%)</td>
<td>--</td>
</tr>
</tbody>
</table>

One of the most revealing comparisons between staff and patient perceptions concerns the ability of staff members caring for NESPs to speak Spanish. Most of the physicians interviewed reported that they spoke "a few words" of Spanish. However, the NESPs cared for by 9 (50%) of the residents and 2 (67%) of the attendings, reported that their doctors' command of Spanish was worse than the physicians believed, and often insisted that the doctor spoke no Spanish at all [See Table 57]. The doctors' and patients' answers were more likely to be the same when the physician
spoke fluent Spanish or admitted to speaking no Spanish.

These figures are particularly important because of the tendency of medical personnel to rely on their own command of the language when dealing with NESEPs. As noted earlier, most of the physicians interviewed in this study indicated that they often speak to their NESEPs in a combination of simple Spanish and simple English. If their simple Spanish is not recognized as such by the patients, the physicians' efforts to communicate are likely much less successful than they think.

Table 57. "How well does the doctor speak Spanish?"

<table>
<thead>
<tr>
<th></th>
<th>Correlation</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td>+1</td>
<td>2 (67%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1 (33%)</td>
<td>--</td>
</tr>
<tr>
<td>Residents/</td>
<td>+1</td>
<td>9 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>Med Students</td>
<td>0</td>
<td>8 (44%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>1 (6%)</td>
<td>--</td>
</tr>
</tbody>
</table>

The suggestion that the physicians' Spanish may be less useful than they believe is supported in part by the fact that, while ESPs and their doctors report very similar perceptions of the others' understanding, there is considerable disagreement among NESEPs and their physicians about what was understood by whom. Almost universally the ESPs and their physicians agreed that the doctor understood everything that the patient said [See Table 58]. However, only 11 (61%) of the NESEPs and their residents agreed on how
much the physician understood, and most of this consensus occurred where the doctor claimed to understand "some", but not all of what the patient said. Three (17%) physicians believed that they understood more than their NESPs gave them credit for, and 2 (11%) reported that they missed some things although their patients were confident that the doctors understood everything. Another 2 (11%) patients claimed to be unable to judge how much their physicians comprehended.

Table 58. "How well does the doctor understand the patient?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+1</td>
<td>1 (33%)</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>0</td>
<td>1 (33%)</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>-1</td>
<td>1 (33%)</td>
<td>--</td>
</tr>
<tr>
<td>Residents/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med Students</td>
<td>+2</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>+1</td>
<td>2 (11%)</td>
<td>--</td>
</tr>
<tr>
<td>0</td>
<td>11 (61%)</td>
<td>22 (92%)</td>
</tr>
<tr>
<td>-1</td>
<td>2 (11%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>-2</td>
<td>-</td>
<td>--</td>
</tr>
<tr>
<td>N/A</td>
<td>2 (8%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Just as the ESPs and their physicians were more likely than the NESPs and their doctors to agree about what proportion of the patient's comments and questions the doctor understood, so too was there greater disagreement between the latter about how much the patients could apprehend of what the doctors said. There was consensus between both (100%) of the ESPs and their attendings and 20
(83%) of the ESPs and their residents that the patient always understood the physician; 2 (8%) doctors believed that their ESPs understood more than the patient admitted to, and 2 (8%) believed that their patients did not understand all that they claimed [See Table 59].

Table 59. "How well does the patient understand the doctor?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESP</th>
<th>ESP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+1</td>
<td>1 (33%)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1 (33%)</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (33%)</td>
<td></td>
</tr>
<tr>
<td>Residents/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med Students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+2</td>
<td>3 (11%)</td>
<td></td>
</tr>
<tr>
<td>+1</td>
<td>7 (39%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>0</td>
<td>6 (33%)</td>
<td>20 (82%)</td>
</tr>
<tr>
<td>-1</td>
<td>1 (6%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>-2</td>
<td>1 (6%)</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

However, only 6 (33%) of the NESP's residents and 1 (33%) of their attendings perceived their patients' level of understanding to be the same as that reported by the patient; in all but one instance the doctor spoke fluent Spanish or spoke through an interpreter and the patient claimed to understand everything. Much more frequently, the physician overestimated the NESP's comprehension. Ten (56%) of the residents and 1 (33%) of the attendings believed that their patients understood them better than the patients themselves reported. One (33%) attending admitted that he had no idea how much his patient understood. Again, this trend carries very serious consequences because what passes
between doctor and patient is not conversational language as
occurs with the ESPs, but the most basic words and phrases.

The patient's opportunity for discussion and the
physician's willingness to entertain questions is another
standard issue in the literature on the discrepancies
between patient and physician perceptions and their
connection to communication. Discrepancies between the
physician's and patient's perceptions of this opportunity
are particularly associated with poor communication [Bain,
1976; Korsch & Negrete, 1972; Reynolds, 1978; Waitzkin &
Stoeckle, 1976]. In the same way that they often
overestimate the length of their consultations, many
physicians have been shown to misjudge the opportunity that
they give patients to ask questions [Bain, 1976; Korsch &
Here, too, patients are much better at assessing the
opportunity for discussion that their physicians provide
[Bain, 1976; Korsch & Negrete, 1972; Reynolds, 1978;
Waitzkin & Stoeckle, 1976].

Physicians caring for ESPs in this study were almost
all confident that they gave their patients "ample
opportunity" to ask questions and discuss their concerns and
their patients largely agreed with them: 17 (71%) of the
residents and 1 (50%) of the attendings reported that their
patients had ample opportunity for discussion, echoing their
patients' opinions [See Table 60]. Four (17%) residents
stated that their patients had greater opportunities for discussion than the patients reported, while 3 (13%) of the residents and 1 (50%) attending responded that they provided less opportunity for discussion than their patients believed themselves to have. In only one instance did a patient report that the physician provided little time for discussion.

Table 60. "How much opportunity does the patient have for discussion with the doctor?"

<table>
<thead>
<tr>
<th></th>
<th>Correlation</th>
<th>NESP%</th>
<th>ESP%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attendings</strong></td>
<td>0</td>
<td>2 (67%)</td>
<td>1 (50%)</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>1 (33%)</td>
<td>1 (50%)</td>
</tr>
<tr>
<td><strong>Residents/ Med Students</strong></td>
<td>+2</td>
<td>--</td>
<td>1 (4%)</td>
</tr>
<tr>
<td></td>
<td>+1</td>
<td>7 (39%)</td>
<td>3 (13%)</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>7 (39%)</td>
<td>17 (71%)</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>2 (11%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td></td>
<td>-2</td>
<td>2 (11%)</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

The meaning of the correlations between the NESP% and their physicians is not so clear, however. Seven (39%) of the residents and 2 (67%) of the attendings agreed with their patients about the opportunity afforded them for discussion; in 5 of these 9 instances the physician either spoke Spanish fluently or was accompanied by a translator, and both parties agreed that there was ample discussion. Yet, in another 3 cases, the doctor and patient agreed that the patient's opportunity for discussion was limited by poor communication, and in the 1 remaining the patient insisted
that their very simple talk was sufficient discussion as he did not question the doctor.

Of the 7 (39%) residents who reported that their NESPs had a greater opportunity for discussion than the patients recognized, 4 suggested that the patient had "ample" opportunity, 2 of whom used a translator to speak with the patient. The other 3 noted that their patients had "some" or "little" opportunity for discussion where the patients believed that they had "little" or "none at all". Three of the 4 (22%) residents who said that their patients had less opportunity for discussion than the patient reported claimed that they had "little" opportunity because of the language barrier; however, 2 (11%) of these patients stated that they had ample opportunity for discussion.

While comparing patient and physician perceptions on this issue does seem to confirm the proposition that good communication occurs when the physician speaks the patient's language or uses a translator, it is of much less value in demonstrating what takes place where there is a language barrier between the doctor and patient. The physicians interviewed here were aware that the language barrier limited their patients' opportunities for discussion. Moreover, while many NESPs indicated that they did have unanswered questions and wanted more discussion, a number of others expressed expectations of their interactions with their doctors that did not include detailed conversation.
In conclusion, the differences between the perceptions of NESP's and their physicians and those of ESP's and their doctors do tend to indicate that a language barrier poses a serious obstacle to a shared perception of medical interaction. NESP's physicians appear more likely to misperceive the amount of time that they spend with their patients, misjudge how well they speak their patients' language, and consequently overestimate both how much the patients comprehend of what is said to them and how much they themselves understand of what their patients say. That these exchanges, described by many of these physicians as quite limited in scope and detail, should be perceived so differently by doctor and patient underscores the severity of the communication gap between them. This data also suggested that different expectations of medical care, many of which may be culturally based, may influence patients' and physicians' perceptions of their interaction in ways that both hinder communication and conceal fundamental misperceptions.

Perceptions of nursing personnel and their patients

The use of patient-practitioner perceptions studies as a measurement of communication has not yet been extended to nurse-patient encounters. However, the premise that good communication between caregiver and patient creates a common view of their interaction would appear to apply equally to all areas of health care. Nurses' more frequent contact
with their patients, and the less technical and more often intimate content of their conversation, suggest that research into nurse-patient perceptions could produce valuable information on more general communication in hospital settings. In this study 45 nurses were interviewed about their interaction with 23 NESPs and 23 ESPs.

As in the physician section of this study, the question of number of visits to the patient's bedside revealed little difference between the perceptions of NESPs and ESPs and their nurses. Fifteen (65%) of the nurses from each group reported the same number of visits as their patients had reported [See Table 61]. It is possible that perceptions differed more frequently, but that the phrasing of the fixed alternative responses affected this correlation; many nurses and patients reported that the nurse visited "more than 5 times" per shift, the highest possible answer, without being required to be more specific. In each group, 5 (22%) of the nurses stated that they visited their patients slightly more frequently than the patients had indicated, and 3 (13%) slightly less often than the patients had claimed.

Table 61. "How often does the nurse visit the patient?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+1</td>
<td>5 (22%)</td>
<td>5 (22%)</td>
</tr>
<tr>
<td>0</td>
<td>15 (65%)</td>
<td>15 (65%)</td>
</tr>
<tr>
<td>-1</td>
<td>3 (13%)</td>
<td>3 (13%)</td>
</tr>
</tbody>
</table>
Nurses caring for NESPs were slightly more likely than those caring for ESPs to report that their visits were longer than the patient perceived them to be. While 9 (39%) of the nurses caring for ESPs reported their visits to be the same length as their patients indicated, only 5 (22%) of those caring for NESPs responded similarly [See Table 62].

Table 62. "How much time does the nurse spend with the patient during a visit?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>+2</td>
<td>4 (17%)</td>
</tr>
<tr>
<td></td>
<td>+1</td>
<td>9 (39%)</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>5 (22%)</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>3 (13%)</td>
</tr>
<tr>
<td></td>
<td>-2</td>
<td>1 (4%)</td>
</tr>
<tr>
<td></td>
<td>-3</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-4</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

Thirteen (56%) of the NESPs' nurses believed that they spent more time with their patients than the patients had stated, compared to 10 (43%) of the ESPs' nurses. Although there is no available research demonstrating that patients' perceptions of the length of their nurses' visits are more accurate than the nurses' own, such an extrapolation from the literature on physicians' perceptions is not altogether unwarranted, and suggests that nurses are more likely to overestimate the time they spend working with, and talking to NESPs.

As with the physicians, many of the nurses caring for NESPs stated that they were able to speak more Spanish than
their patients believed them to be capable of. Only 5 (22%) of these nurses perceived their ability to speak Spanish at the same level that their patients reported [See Table 63]. More commonly, the nurses considered their Spanish to be better than their patients did: 16 (70%) reported that they spoke "a few words" of Spanish or that they spoke it "somewhat", while most of their patients replied that the nurses spoke no Spanish at all. Again, this is a particularly important finding because many of the nurses reported that they spoke to their patients in simple Spanish and simple English. As in the case of the doctors, what the nurses believed to be communication in Spanish may have been meaningless to their patients.

Table 63. "How well does the nurse speak Spanish?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+2</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
<tr>
<td>+1</td>
<td>16 (70%)</td>
<td>--</td>
</tr>
<tr>
<td>0</td>
<td>5 (22%)</td>
<td>--</td>
</tr>
<tr>
<td>-1</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
</tbody>
</table>

The nurses' assessment of their skills in Spanish may have made them poor judges of both their own and their patients' ability to understand what transpired between them. Only 7 (30%) of the nurses caring for NESPs shared their patients' perception of their understanding, most of them recognizing that they understood only "some" of what their patients said [See Table 64]. Another 7 (30%)
believed that they understood more than what their patients indicated, and 4 (22%) reported that they understood less than their patients suspected that they did. These figures compare to the 19 (83%) of the nurses caring for ESPs who agreed with their patients that they understood everything that their patients said.

Table 64. "How well does the nurse understand the patient?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESP</th>
<th>ESP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+2</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>+1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>-1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>N/A</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

The NESP's nurses were also likely to overestimate their patients' ability to understand what they said. Only 6 (26%) of the NESP's nurses perceived their patients' comprehension to be equal to that reported by the patients themselves, as compared to 22 (96%) of the ESP's nurses; in all but 2 cases they agreed that the patient understood only some or a little of what was said [See Table 65]. Thirteen (56%) of the nurses caring for NESP stated that their patients understood them better than the patients themselves believed; more than half of these nurses misjudged by two or more categories of measurement. Only 3 (13%) suggested that the NESP did not understand everything that the patients thought they did. As the language that
the nurses used with the NESP's was so often simplistic, seldom approaching the level of conversation that existed between the ESP's and their nurses, this difference indicates that what little communication did take place between the nurses and their NESP's was of extremely poor quality.

Table 65. "How well does the patient understand the nurse?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESP's</th>
<th>ESP's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+3</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
<tr>
<td>+2</td>
<td>7 (30%)</td>
<td>--</td>
</tr>
<tr>
<td>+1</td>
<td>5 (22%)</td>
<td>--</td>
</tr>
<tr>
<td>0</td>
<td>6 (26%)</td>
<td>22 (96%)</td>
</tr>
<tr>
<td>-1</td>
<td>3 (13%)</td>
<td>--</td>
</tr>
<tr>
<td>-2</td>
<td>--</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>N/A</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
</tbody>
</table>

The question of the patients' opportunity for discussion is only slightly more meaningful in reference to interaction with the nurses than with the doctors. Among the ESP's and their nurses, 15 of the 17 (74%) pairs agreed that they had "ample" opportunity for discussion [See Table 55]. Another 6 (26%) nurses reported that their patients had more opportunity than the patients believed themselves to have. These figures compare with only 10 (43%) of the NESP's and their nurses who perceived available discussion time equally. However, 2 pairs agreed that the patient had little opportunity for discussion, and 2 pairs agreed that the patient had only some opportunity.

More importantly, the cultural expectations of many of
the NESP takes the value of this data in question. Of the 8 patients who agreed with their nurses that they had some or ample opportunity for discussion, 6 insisted that they had no need for discussion with the nurses and that they anticipated none. The 5 (22%) NESP whose nurses believed them to have less opportunity for discussion than they expressed also placed more value on such conversation than their patients did. The NESP's understanding of the nurses' role and their own appropriate behavior with the nurses may have limited their desire for such discussion.

Table 66. "How much opportunity does the patient have for discussion with the nurse?"

<table>
<thead>
<tr>
<th>Correlation</th>
<th>NESP</th>
<th>ESP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+3</td>
<td>2 (9%)</td>
<td>--</td>
</tr>
<tr>
<td>+2</td>
<td>2 (9%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>+1</td>
<td>3 (13%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>0</td>
<td>10 (43%)</td>
<td>17 (74%)</td>
</tr>
<tr>
<td>-1</td>
<td>4 (17%)</td>
<td>--</td>
</tr>
<tr>
<td>-2</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
<tr>
<td>N/A</td>
<td>1 (4%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Nonetheless, while the 7 (30%) NESP whose reported their patients to have more opportunity for discussion than recognized by their patients compares to the 6 (26%) of the ESP nurses who responded similarly, these figures represent an important difference in scale. Most of these NESP indicated that they had little or no opportunity for discussion, while the ESPs reported some opportunity. In 4 (17%) of these cases, the nurses' perceptions are
significantly different from the NESPs in this regard. Two patients who had been hospitalized outside the U.S. previously were particularly upset at what they perceived to be the nurses' lack of friendly attention, although their nurses reported no such problem; another patient was not even certain who his nurses were. As in the case of the physicians, the importance of shared perceptions of the patients' opportunity for discussion as an indicator of verbal communication is diminished by factors from outside of their actual interaction.

Generally, there are some important differences between the perceptions of nurses caring for NESPs and ESPs and their respective patients regarding their interaction. If the indications of the literature on doctor-patient communication are extended to the nurse-patient encounter, these differences suggest that a language barrier between nurse and patient fosters misperceptions of their interactions. Like physicians, nurses caring for NESPs appear more likely to misjudge the amount of time that they spend with their patients, overrate their ability to speak their patients' language, and consequently overestimate both how much the patients comprehend and how much they themselves understand of what their patients say, even when it is in the most simplistic terminology possible. Because the communication between nurses and their patients focuses less on technical subjects and more on basic human needs,
the effect of a language barrier between nurse and patient may have a more immediate impact on the patient's total care than would poor communication with a physician.

Perceptions of other personnel and their patients

The duties, goals, training, and research of the many allied health and social service professionals within the hospital vary widely. While the research of dieticians and therapists has paid limited attention to patient-practitioner communication, social workers and hospital chaplains have extensive bodies of literature on effective interaction; patient representatives, much of whose job involves talking with patients, are members of a field still so young that it has almost no professional literature. In none of these fields has there been any research into patient-practitioner perceptions, and how differing perception of their interaction may relate to communication.

However, as in the case of nurses, it is not inappropriate to presume that the conclusions drawn from research into doctor-patient interaction and theories about "commonness" in effective communication can be applied to ancillary hospital personnel in their work with patients. Moreover, because in many instances ancillary personnel meet with a patient only once, the effectiveness of their communication in that one encounter is of particular importance, as there may be no later opportunity to gather more information or clarify misconceptions.
This section involved 13 allied health and social service staff members -- 3 dieticians, 1 therapist, 2 social workers, 2 chaplains, and 5 patient representatives/interpreters, one of whom was a volunteer. Unfortunately, as in the case of the attending physicians, the numbers here are not large enough to be meaningful, and they break down between NESPs and ESPs in such a way that this portion of this study is inconclusive. The results of these staff-patient correlations are reported in Appendix V.

One observation may be made, however, about the staff who communicated with their patients in fluent Spanish. The perceptions of the patient representatives/interpreters and their patients, and of the social worker and patient who spoke exclusively through an official interpreter, were as consistently similar as those of the ESPs and their caregivers. This similarity suggests that staff members who speak with NESPs through an interpreter can achieve a level of communication comparable to that of their interactions with ESPs.

The appropriate use of translation is a subject which has only recently received any attention among health care professionals. Although interpreting is itself an old art, its formal use in medical settings is a new development which will require both special technique and sensitivity to the ethical problems created when a third party is introduced into the therapeutic relationship between patient
and caregiver. This issue is the subject of the following chapter.

**Notes to Chapter 4**

1. **The category "consulting physician" is omitted as only 1 of the patients recognized that a consultant was involved in his care, and no consultants were interviewed. Because of the small numbers of therapists, dieticians, chaplains, and social workers interviewed, their responses are reported in 2 combined categories. Both of the 2 volunteers interviewed worked as volunteer interpreters for the patient representatives' office, and are reported as patient representatives/interpreters.**

2. **Only a handful of staff members refused to be interviewed, usually when they were asked to participate a second or third time. In each case the objection was that they had too much else to do and not enough time.**

3. **Both the chaplains and the patient representatives/interpreters worked on assigned units and could be identified according the patient's room number.**

4. **For patient ratings of staff members' Spanish, see pages 216-17 and 225-26.**

5. **The "NESP staff" and "ESP staff" are not true groups, but simply convenient labels for the staff members who cared for NESPs and ESPs respectively. A number of staff members, particularly residents, were involved in the care of patients from both subject groups, and are represented in both NEsp staff and ESP staff.**

6. **Because of the pressing need to keep the staff survey as brief as possible, the NEsp staff was asked only how they communicated with the given NEsp enrolled in the study, rather than with both the specific patient and NESPs in general. The somewhat different foci of the 2 questions may have affected the comparability of the 2 groups' answers. Additionally, there is no repetition of respondents among the ESP staff, while some of the NEsp staff answered this question in connection with more than one patient.**
7. The words commonly known by medical personnel included "cómo está" (how are you), "respira profundo" (breathe deep), "dolor aquí" (pain here), and "levantese" (get up). Nurses generally knew "dolor" (pain), baño (bathroom), and "agua" (water). With the exception of greetings, almost all of the Spanish words known by the staff were task-oriented. Pronunciation varied widely, and many, unsure whether the words they knew were nouns or verbs, used them as both, depending on the circumstances.

8. A fourth-year medical student on a surgery rotation described residents and nurses as constantly referring to NESP's, particularly young male trauma victims, as "dirtballs", one of medicine's particularly negative labels. He also remarked that staff members commented regularly that some NESP's were not really sick, but that they wanted to stay hospitalized for the 3 meals a day and the color television.

9. This portion of the staff survey corresponds to questions 2, 3, 4c, 5, 7, and 8 on the patient questionnaires. See Appendix II for the complete text of the patient interview questions.

10. One OB clinic patient insisted that she had seen no doctor, except during delivery, during her 3 days in the hospital. Her intern reported having visited her every morning at about 6:15.
Chapter 5
The Ethics, Economics, and Legal Aspects of Translation

The metaphor of the patient as a stranger in the health care system has been one of the most fruitful images in contemporary ethics, evoking a new vision of the therapeutic relationship and illustrating patients' need to have an active role in their own care. The hospital patient who speaks no English is an excellent worst-case example of the stranger that demonstrated how vital a role good communication between caregivers and their patients plays in ethical health care. Not only a stranger to the world of the hospital and its many staff members as individuals, the NESP is often unfamiliar with the presuppositions of Western scientific medicine, the prevailing culture of the larger community, and the language in which these differences could be discovered and explained. Although recognized in theory to be the very sort of patient with whom good communication is demanded of caregivers, the NESP's inability to speak English limits most such attempts. Without the human presence that speech creates, NESPs are isolated and abandoned even as their caregivers endeavor to help them.

The results of the present study demonstrate that the estrangement experienced by many hospital patients can be overcome or heightened by their interaction with caregivers, depending on the extent of the communication that takes
place between them. Some of the study's findings were expected; some were surprising. In light of the new emphasis that most of the health care professions now give to communication with patients, many of the findings were quite disturbing, and demonstrated how little ethical theory may influence the actual behavior of health care professionals when they are confronted with practical obstacles to providing ethical care.

Communication, Consent, and Translation for NESPs

As was anticipated, the majority of the NESPs interviewed were immigrants whose income and level of education placed them among the most disadvantaged members of the American population, clearly strangers to the world of their caregivers. NESPs were most commonly hospitalized for childbirth and nonelective surgery, including trauma, but they were more likely than ESPs to come directly to the hospital emergency room for treatment, regardless of their problem. NESPs' reliance on the emergency room may reflect their lack of options in the health care system, as the literature on access to care suggests that NESPs are unlikely to turn to the hospital because of their inability to speak English.

NESPs were much less able than ESPs to identify the role and duties of the hospital staff members who treated them; in particular, NESPs were less able to distinguish among the medical personnel, and their assumptions about
staff roles were strongly influenced by the staff member's gender. NESP's identified staff members who spoke Spanish much more readily than those who did not, irrespective of their roles. Although few NESP's were able to distinguish the various allied health personnel from physicians or nurses, the role of such professionals in the care of NESP's also appeared to be quite limited in contrast to their work with ESP's. Surprisingly, this was especially true in the case of hospital chaplains, who, unlike most others, visit patients without a physician referral.

As was expected, communication between NESP's and their caregivers was found to be quite limited in almost every way when compared to that of their English-speaking counterparts. Many NESP's reported that, because of the language barrier, they and their caregivers spoke with each other infrequently, and then only in simple words incapable of expressing complex factual information or intangible concepts. Physicians were the most likely to use an interpreter when speaking with NESP's, but often the "interpreter" was a family member whose ability to translate was unknown, and who did not always share information with the patient. NESP's who exhibited any ability to speak or understand English were seldom provided translation, and many patients whose caregivers usually spoke to them in simple English reported that their comprehension of what was said was quite limited.
While almost all of the NESP's knew their diagnoses, many did not know what treatment they were receiving, understand how it worked, or know how long it would take to be effective. Remarkably, NESP's knowledge and understanding of their conditions and treatment was inferior to that of the ESP's irrespective of the ways in which the NESP's caregivers tried to communicate with them. This finding suggests that a patient's inability to speak English influences staff-patient communication negatively in ways that go beyond the language barrier itself.

Despite the quantitative and qualitative differences in the communication between staff members and the NESP's and ESP's, patients in both groups reported very similar levels of satisfaction with their interaction with caregivers. This finding was quite unexpected, given the large body of literature linking patient satisfaction to the quality of patient-caregiver communication. It appears that the crucial factor here is the patients' expectations of their interaction, and it seems likely that because the NESP's expected little communication with the hospital personnel, they were generally satisfied with whatever communication took place. This phenomenon probably contributed to some of the NESP's limited knowledge of their conditions as well. Staff members who easily could have provided considerable information to their NESP's in Spanish may not have done so because the NESP's appeared satisfied with relatively little.
The staff interviews revealed that while the majority of the personnel in every staff category found that the language barrier impaired their own abilities to care for NESP's, a substantial number believed that the quality of care that patients receive is ultimately independent of their communication with caregivers. Even many of the staff who found fault with their own work with NESP's were unwilling to criticize the overall care that NESP's receive. Ironically, the sentiment that overall care did not vary with the quality of staff-patient communication was expressed most frequently by nurses, whose profession has placed the greatest emphasis on the role of good communication and the need for caregivers to know their patients as autonomous individuals. Conversely, physicians, often criticized for their paternalistic attitude and poor communication skills, were the most conscious of the practical and ethical problems caused by a language barrier.

Staff members reported that working with NESP's was difficult because they could not ask them questions or explain anything to them, and because the patients themselves could not ask questions or express their needs. A number complained that it took too long to find an interpreter or that something was always lost in translation when an interpreter was used. Many claimed that other staff members were unwilling to do the extra work often required to overcome these problems. Several also stated that they
became frustrated when working with NESP's, a reaction which has been shown to cause caregivers to avoid their patients, minimize the importance of their needs, or treat them with hostility.

When the perceptions of the staff and patients were compared, it was clear that many staff members were unaware of how seriously their communication with NESP's was impaired. Staff members believed that their own proficiency in Spanish, their understanding of their patients' comments, and their patients' comprehension, were considerably better than the patients reported. The great difference in their perceptions attests to a severe communication gap that is not bridged by the simplistic exchanges that often occurred between the NESP's and their caregivers.

From the results of this study it is evident that the NESP's typical interaction with hospital staff members had little in common with any of the three models of health care advocated by contemporary ethical theory -- neither the coVENemental relationship based on love and respect for human dignity, the contractual relationship based on autonomous persons' self-interest, nor even the customer-provider relationship based on consumer rights and the ability to pay. To the contrary, as one physician in the study remarked, the care that NESP's received was often very similar to veterinary medicine or neonatal pediatrics; unable to express their needs, the patients became little
more than voiceless bodies, passive recipients of treatment determined and administered by equally silent, paternalistic caregivers.

Such treatment, although widely condoned, is morally abhorrent. NESP's are not animals or infants, but persons whose adulthood and very humanity entitle them to respect from those professionals to whom they turn for help. Most are thoroughly capable of speech and quite competent to make their own decisions, and they have the right to make free and informed choices about the care that they receive. While direct conversation with NESP's may be impossible for staff members who speak only English, it remains the professional ethical duty of all health care practitioners to treat NESP's with the dignity that all human beings deserve, and their legal obligation to ensure that NESP's receive the information necessary to make treatment decisions.

**NESP's under informed consent law**

The failure of ethical standards to motivate the staff to seek good communication with their NESP's raises the question of whether legal requirements about such communication are met, and whether NESP's receive the medical information to which they are entitled under laws governing informed consent. In American legal theory, informed consent is defined as the exchange of information between doctor and patient that protects the patient's right to
knowledge needed to consent to or refuse medical treatment [Faden & Beauchamp, 1986; Katz, 1984]. Prevailing legal theories on informed consent have much in common with ethical theories about the doctor-patient relationship; both recognize the fundamental importance of the patient's autonomy and the centrality of open communication of medical information, professional opinion, and personal beliefs in maintaining a therapeutic relationship [Katz, 1977; Schultz, 1985]. Clearly, the open discussion essential to informed consent defined in this way is seriously impeded by a language barrier between the patient and physician.

In theory, the law considers the exchange of information that takes place in the consent process to be the most important communication possible between doctor and patient [Katz, 1977; Schultz, 1985]. Theoretically, by requiring that a physician present a consent form to a patient undergoing a certain procedure, the law ensures that such communication takes place, that basic information is given to every patient for whom treatment is recommended, and that he or she has a formal opportunity to consider whether to agree to or refuse that treatment.

Theory aside, statutory and case law on informed consent focuses much more narrowly on the physician's one-time disclosure of the specific risks inherent in a procedure, and emphasizes the document as evidence of disclosure and the patient's acknowledgment and acceptance
of those risks. The legal requirements for the use of the consent form vary from state to state. Texas' informed consent law is unique in that it specifies every procedure for which a consent form is required (the so-called "List A and List B procedures"), prescribes the document's wording, and lists the risks which must be disclosed in writing for each procedure [Tex. Rev. Civ. Stat. Ann., 1985]. The consent document itself contains all of the information that the law requires be provided to the patient: it explains the purpose of consent and the consent form, and, to be valid, must name the procedure(s) to be performed and physician(s) involved, and include a procedure-specific risk-disclosure sticker [Meisel & Kabnick, 1979; Richards & Rathbun, 1983].

According to the Texas Medical Disclosure Panel, the body of medical and legal experts appointed by the Texas legislature to draft the standard consent form and oversee the regulation of consent, there is sufficient information on the form for any patient to make an informed decision to consent to or refuse treatment [Richards & Rathbun, 1983]. While additional discussion, either of the form itself or of the procedure in general, is certainly welcomed, it is not required. Under Texas law there is a legal presumption that the doctor's duty to disclose has been fulfilled if the patient signs a valid consent form before a witness [Tex. Rev. Civ. Stat. Ann., 1985].

In common practice, obtaining patients' signatures on
consent forms is problematic no matter what language they speak [Faden & Beauchamp, 1986; Miller & Butler, 1982]. Many patients understand neither the ethical or legal nature of informed consent even if they understand the wording of the consent document. If they discuss an upcoming procedure with their physicians, they seldom associate the process with the act of signing its consent form. While they are often aware that they must sign some papers before undergoing tests or surgery, they may believe that the consent form is a release which they must sign in order to be given any medical treatment.

Moreover, even patients who understand English may receive little encouragement to read the form fully, especially if the physician, his or her representative, or the witness is in a hurry. Many patients sign consent forms without reading them to avoid delaying their caregivers. Some patients may refrain from reading a consent form because they do not understand its true purpose; some may fear legal-looking papers and sign without reading it as an act of trust in their physicians; still others may be ashamed of poor reading skills and too embarrassed to ask for help. In these contexts, the document's statement "I (we) certify that this form has been explained to me, that I (we) have read it or it has been read to me, ... and that I (we) understand its contents" becomes only a legal formality.

The effects of a language barrier on the legal validity
of consent are not clear, for the law in many states accepts as valid consent the signature of a patient who may not have read or understood the form if the patient is competent and if he or she signed the form voluntarily [Faden & Beauchamp 1986; Meisel & Kabnick, 1979; Miller & Butler, 1982]. A federal court has interpreted Texas law to find that a patient who has signed a consent form is held to have read it, even it when he or she has not actually done so [Perdue, 1985]. While consent is almost universally valid if the patient waives the right to be informed [Perdue, 1985], the issue of unread or misunderstood consent forms has not been settled completely. This ambiguity extends to the issue of patients who cannot read or understand English.

Where a standard consent form is used, traditional contract defenses may be used to rebut the presumption of valid disclosure. Texas law holds that in the event of fraud, mistake, undue influence, lack of opportunity to read the form, blank spaces on the form, mental or drug-induced incompetence, and occasionally blindness, the validity of the consent may be contested [Perdue, 1985; Meisel & Kabnick, 1979]. The inclusion of impaired mental capacity and blindness is based on the rationale that a patient who cannot see or understand the language written on the form cannot make an informed decision without an oral disclosure from his or her doctor or the doctor's representative [Perdue, 1985].
When the Texas Medical Disclosure Panel first mandated the standardized consent form, some hospitals in communities with large Spanish-speaking populations tried to adapt the form for use by NESPs. Some, including the study hospital, translated the form into Spanish. Nonetheless, many hospitals' risk management officials soon decided that because individual hospital's translations, however accurate, were not the standardized form that the Panel required, hospitals using such translations might be open to charges of having failed to obtain valid consent under the law.

Moreover, there were practical drawbacks to a consent form in Spanish. The idiomatic sense of a written translation could be misunderstood by patients whose dialect was different from that of the form's translator. A Spanish-speaking staff member would be needed to fill in the form's blanks in Spanish and attach a Spanish risk-disclosure sticker for each procedure. In addition, the high rate of illiteracy among immigrants and older native-born NESPs meant that in many cases such forms alone would not be adequate; someone would still need to be available to read the form to the patient when he or she was not able to do so.

By 1983, administrators at the study hospital decided that it was both more prudent and more practical to rely exclusively on the oral translation of consent forms for
persons who did not speak English. Translating consent forms became one of the specific duties of the official interpreters on the patient representatives staff, and medical and nursing personnel were instructed to call the patient representatives to arrange for translation whenever a NESP needed to give formal consent. To document that such oral translation had been provided, the hospital’s consent form includes a line at the bottom of the form marked "translator's signature".

**Reviewing NESPs consent forms**

The great majority of the doctors and many of the nurses interviewed about their work with NESPs reported that they spoke to their patients through an interpreter for anything "important", and several cited consent as an example of an "important" communication. To determine the frequency with which legally mandated disclosures to NESPs were translated, and to assess the quality of the information that was provided to them, the study included a review of the medical records of the 66 adult Hispanic NESPs admitted to the study hospital during the month of October, 1985. The NESPs' chart notes, discharge summaries, and consent forms were read and examined for documentation of the translation of important disclosures, with particular attention paid to the translation of consent forms.¹

The chart notes about communication with NESPs were infrequent and unsystematic. Neither the incidence of
problems in communication nor the staff's general use of interpreters could be discerned from the NESP's progress notes. In the few instances where there was mention of an interpreter being called to translate for a doctor or nurse, the patient was about to undergo a difficult procedure, or required detailed instructions for self-care. The reporting of translation in the progress notes or discharge summary appears to have been included as "defensive documentation" in situations which posed considerable physical risk to the patient, and a concomitant risk of litigation to the physician.

However, as anticipated, the NESP's consent forms provided a very clear indication of the staff's use of interpreters and of the importance that the staff placed on communication in the informed consent process as defined by law. As many of the study's NESP's underwent procedures which required formal consent, tallying their translated consent documents provided substantial evidence about the type of information that they received in Spanish about those procedures. In each case where a procedure requiring formal consent was performed, or where the patient was enrolled in a research protocol, the related consent form was examined for a translator's signature, and the name and role of the translator in each case was recorded. The number and types of procedures for which consent was obtained, and the role of the person who served as the
translator were then tallied. Of the 66 NESPs, 41 had undergone procedures which required formal informed consent by the end of their stay\textsuperscript{3}, with a total of 51 procedures among them [See Table 67]. Of the 51 corresponding consent forms, slightly more than half bore the signature of a translator.

| Table 67. Procedures and translation of consent forms |
|---------------------------------|----------|----------|----------|----------|
| Total NESPs | NESPs with consent procedure | Total consent forms | Consent forms translated | Consent forms untranslated |
| 66 | 41 (62%) | 51 | 28 (55%) | 23 (45%) |

The procedures for which consent was required can be broken into 5 categories: diagnostic (e.g. arthrogram), therapeutic (e.g. coronary artery bypass graft), combined diagnostic-therapeutic (e.g. laparotomy with possible appendectomy), childbirth, and research. The frequency with which translation was obtained for consent varied from 86\% for combined diagnostic-therapeutic procedures, to 0\% for participation in research protocols [See Table 68]. More significant, however, because of the numbers of procedures involved, are the high rate of translation for therapeutic procedures and the extremely low rate for childbirth. Of the 21 therapeutic procedures, all but 3 consent forms were translated, while in only 1 of 15 cases of childbirth did the patient receive translation for her consent.
Table 68: Procedures and translation of consent forms

<table>
<thead>
<tr>
<th>Type of procedure</th>
<th>Total procedures</th>
<th>Translated consent forms</th>
<th>Untranslated consent forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>7</td>
<td>4 (57%)</td>
<td>3 (43%)</td>
</tr>
<tr>
<td>Therapeutic</td>
<td>21</td>
<td>18 (86%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Combination</td>
<td>6</td>
<td>5 (83%)</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Delivery</td>
<td>15</td>
<td>1 (7%)</td>
<td>14 (93%)</td>
</tr>
<tr>
<td>Research</td>
<td>2</td>
<td>0</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>28 (55%)</td>
<td>23 (45%)</td>
</tr>
</tbody>
</table>

Where translation was documented on the consent form, the translator was a member of the hospital staff in 54% of the cases, but an official interpreter or certified by the hospital as a volunteer interpreter in only 43% [See Table 69]. In those situations where someone other than a hospital employee provided the translation, it was most frequently a member of the patient's family. Friends of the patient also translated consent forms. In several instances, the translator was either unidentifiable or the translator's signature was illegible.

In cases where the translator was an official interpreter or a staff member certified by the hospital as an interpreter, one may assume that the entire consent form was translated aloud for the patient in correct Spanish, that the patient was given an opportunity to ask questions,
Table 69: Translator role

<table>
<thead>
<tr>
<th>Translator</th>
<th>Consent forms translated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital agents</td>
<td></td>
</tr>
<tr>
<td>Interpreter</td>
<td>12 (43%)</td>
</tr>
<tr>
<td>Physician</td>
<td>2  ( 7%)</td>
</tr>
<tr>
<td>Nurse</td>
<td>2  ( 7%)</td>
</tr>
<tr>
<td>Other staff</td>
<td>2  ( 7%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18 (64%)</strong></td>
</tr>
<tr>
<td>Not hospital agents</td>
<td></td>
</tr>
<tr>
<td>Family member</td>
<td>3  (11%)</td>
</tr>
<tr>
<td>Friend</td>
<td>2  ( 7%)</td>
</tr>
<tr>
<td>Unidentifiable</td>
<td>3  (11%)</td>
</tr>
<tr>
<td>Illegible</td>
<td>2  ( 7%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10 (36%)</strong></td>
</tr>
</tbody>
</table>

and that accurate explanations were given in response. The interpreters who worked as patient representatives were fully bilingual, and considered themselves to be advocates for the NESP's whom they served; the other certified interpreters were also bilingual, and were trained in translating consent forms by the patient representatives.

However, the same cannot be said where the translator was a member of the patient's family, a friend, or even another staff person. The quality of these translations is questionable, both in terms of accuracy and completeness, as these individuals' fluency in both English and Spanish is unknown. If family members and friends shared the patient's background, it is likely that their education was limited and that they had little expertise in formal translation.
And, where the translator was a family member or friend of the patient, the explanation of the document and the nature and risks of the procedure may have been hampered by unfamiliarity with medicine in general and consent in specific.

Both of these problems can extend to hospital personnel as well. From the staff interviews it appears that fully bilingual doctors and nurses were rare, and that the language skills of some who believed their Spanish to be adequate were not so highly rated by their NESPs. Moreover, many reported using nonmedical personnel, such as members of the housekeeping staff, as translators because they were readily available. Neither the conceptual medical knowledge nor the medical vocabulary of such persons is likely to be sufficiently broad for accurate translations.

The surgical staff were the most likely to obtain translation for their NESPs' consent forms, as well as the most likely to use agents of the hospital as translators. Of the 24 procedures performed on surgical patients, slightly more than two-thirds of the consent forms were translated, and more than two-thirds of those forms were translated by hospital staff [See Table 70]. This comparably high rate may be due to fact that surgery often carries significant risks, and almost every surgical procedure requires a consent form. A high incidence of malpractice litigation against surgeons also may make them
more conscious than other physicians of the need for comprehensible disclosure of risks to all patients. Internists obtained translation for their patients' consent forms in 4 of 6 cases, but in all but one instance they relied on the patients' friends or family to do the translation.

Table 70: Rate of translation and translator role by service

<table>
<thead>
<tr>
<th>Service</th>
<th>Total # of forms</th>
<th>Untranslated</th>
<th>Translated by interpreter</th>
<th>Translated by other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>24</td>
<td>7 (29%)</td>
<td>12 (50%)</td>
<td>5 (21%)</td>
</tr>
<tr>
<td>OB/Gyn</td>
<td>21</td>
<td>14 (67%)</td>
<td>5 (24%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Medicine</td>
<td>6</td>
<td>2 (33%)</td>
<td>1 (17%)</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>23 (45%)</td>
<td>18 (35%)</td>
<td>10 (20%)</td>
</tr>
</tbody>
</table>

Obstetricians/gynecologists were by far the least likely to obtain translation for their patients' consents. As noted above, only 1 of 15 women admitted for delivery received translation for her consent form. Of the other consent forms that were translated, most were for bilateral tubal ligation (BTL), a sterilization procedure for which consent is carefully regulated by state law. One of the 5 BTL patients did not receive translation for her consent, although for 3 of the remaining 4 women, translation was provided by a certified interpreter.

All of the women who underwent BTL had given birth
during that same admission, and it is unclear why the OB staff responsible for obtaining consent for sterilization was so much less concerned with providing translation for these same women for consent at delivery. It may be that inasmuch as many OB patients are followed in the hospital's prenatal clinic or the OB clinic of an affiliated PPO, it was assumed that the patients had received adequate information prior to admission. Yet this rationale would also apply to BTL patients, who often sign a bilingual consent form in the clinic before admission to the hospital. It is also possible that no one is available to translate in the middle of the night when many OB patients are admitted already in labor.

Two OB patients who did not have their consent forms translated were also the only patients of the 66 NESPs whose charts reported complications during the procedure. Both patients required surgery under general anesthesia: one needed an emergency Caesarian section; one required curettage to stem postpartum hemorrhage. Whether either patient had been informed of the possible need for such surgery, with its attendant risks, is unknown. There is no notation of oral disclosure in either chart, and the documentation available -- the untranslated consent form -- indicates that they were not so informed.

In sum, the chart review reveals that, although the staff members interviewed about NESPs insisted that they
called in an interpreter to translate important exchanges, consent forms were not generally considered to be "important". As indicated in the staff interviews, many of the physicians who did obtain translation relied on whomever was at hand, rather than using official interpreters; fewer than half of the translated consent forms that were executed by a certified interpreter whose language skills were proven. Both the amount of information provided to the remaining patients and its accuracy are suspect, as neither patients' family members and friends nor Hispanic staff members can be expected to provide quality translation.

The law's emphasis on the consent document encourages physicians to ignore the principles of self-determination and open communication behind informed consent, and many medical personnel understand the consent process only in terms of obtaining the patient's signature on the consent form [Faden & Beauchamp, 1986; Katz, 1984]. Yet the finding that few NESPs are provided with accurate translation for their consent forms is much more than an abstract measurement of doctor-patient communication; it raises fundamental questions about the legal validity of such informed consent for patients who speak no English. Is a NESP who signs an untranslated consent form "informed" according to law?

While the contractual concept of comprehensibility appears to include the patient's ability to understand the
idiom in which the consent form is written, the law makes no specific provision for disclosure to patients who do not speak English.\textsuperscript{7} There is no statutory requirement that translation be provided to NESP\Ts, either for oral disclosure or for the written disclosure required for consent. To date, no case contesting the validity of English language consent forms for NESP\Ts has been heard by a Texas court [Holm, 1986]. And although a NESP who is given a standard consent form will not understand its contents, until such a case is won or statutory changes made, physicians will have no specified legal responsibility to ensure that the signed form represents a true consent.

Until as the \textit{de facto} exclusion of language barriers from the grounds for rebutting the presumption of valid consent is successfully challenged, providing translation for NESP\Ts' consent forms will continue to be up to the discretion of the individual physician. Nonetheless, doctors who ignore NESP\Ts' need for information and deny them comprehensible disclosure violate the spirit of informed consent law, if not the letter. They may also underestimate the realities of the current litigious climate. Few NESP\Ts consider suing for damages, even when true malpractice has occurred [Holm, 1986]. This reluctance is due to their unfamiliarity with the U.S. legal system and the ethical principles upon which it is based, cultural values which discourage litigation, and the language barrier which may
separate them from most lawyers. However, patients are not always the only parties with a vested interest in such litigation.

There are at present in Texas two malpractice suits filed on behalf of NESP's by workers' compensation insurance companies. In each case, the suit claims that a worker injured on the job received emergency, inpatient, and follow-up care without being informed about the treatment plan. Each patient signed a consent form for a List A procedure, but each claims that the procedure was never explained and that the consent form was not translated. In both instances the procedure resulted in a poor outcome, and both patients remain partially disabled.

Because the patients allege that they were unaware of the nature of the procedures and the purpose of consent forms that they signed, both suits maintain that the consent forms were invalid and charge the attending physician with malpractice and negligence. A vital part of their argument is the assertion that a patient who speaks no English is not informed by disclosure, written or otherwise, that is not translated. While the goal of the insurance companies is less to obtain justice for the patients than to minimize their own financial losses by forcing the medical staff to pay damages, these cases are likely to set a precedent that will redefine the legal requirements for consent for NESP's throughout the state should they go to trial [Holm, 1986].
It is tempting to speculate about what takes place when a NESP is given a consent form to sign without benefit of translation. What is such a patient told, and in what way? How does the patient react to the document itself, and under what assumptions does he or she sign it? Although final answers to these questions are unavailable, evidence from the NESP interviews suggests that consent forms are not well understood or well received by them.

One of the reasons cited by NESPs for refusing to participate in the study was unwillingness to sign the protocol's required consent document; of the 5 NESPs who refused to participate in the study, 2 were unwilling to sign anything not specifically required by the hospital for the continuation of their medical treatment, although they were quite willing to be interviewed. This general reluctance was also evident among the 25 NESPs who did agree to be interviewed. Three specifically asked to sign the consent form after the interview, rather than before it, to be certain that they did not agree to anything that they did not want to do, even though they were told repeatedly that they could stop the interview at any time. The fact that every NESP was given a copy of the document in Spanish, and that when necessary the form was read aloud to them in Spanish, seemed to be of little consequence. They were suspicious of any activity that required that they sign paperwork.
This negative reaction to the consent form was unparalleled among even the least educated of the ESPs. It suggests that NESPs may be quite intimidated by formal documents, especially when they must trust strangers to explain their purpose, meaning, and implications [Ekunwe & Kessel, 1984]. Many were undoubtedly suspicious of official forms because they could not read. Yet, the Spanish consent form created the same anxiety in literate NESPs, including the 2 with some college education, that was evident among the illiterate patients: many were mistrustful of the form and the intentions of the stranger who sought a signature.

It is possible that some NESPs may be reluctant to sign a consent form because they believe that documents in general create significant liability [Ekunwe & Kessel, 1984]. Even after a comprehensive explanation of the purpose of informed consent, in Spanish, NESPs voiced fears that they were authorizing extra charges or interfering with anticipated insurance coverage by signing the study's consent form (especially those NESPs who were accident victims). More importantly, the majority were concerned that they would be denied all future medical treatment if they refused to sign, despite a lengthy discussion of the voluntary nature of the study.

As most of the study's subjects had already undergone the significant proportion of their medical care by the time that they were interviewed, many had already signed at least
one consent to treatment when they were asked to participate. If the concept of informed consent and the purpose of the consent document had been explained to them at that time, it is likely that the NESPs would not have been so suspicious of the study's consent form. The NESPs' frequently negative reaction suggests that they may have been told to sign earlier consent forms with little explanation and a strong emphasis on the need to sign in order to receive necessary tests and treatment.

A written consent document may create significant distress for NESPs who are unfamiliar with the basic concept of informed consent and who may misunderstand what they are signing and why. In countries other than the U.S., hospital patients do not have a general right to informed consent, and written consent documents, if used at all, are reserved for procedures with dire implications [Ekunwe & Kessel, 1984; Kosovich et al., 1986]. Many of the NESPs contacted expressed disbelief that a signed form would be required for a study in which the researcher intended only to talk with the patient.

Outside of the U.S., a patient's consent to treatment is often implied by the consultation of a physician or admission to the hospital [Kosovich et al., 1986]. In the doctor-patient relationship based on the more traditional paternalistic model, a written agreement for treatment is unthinkable. In such a context, the physician's good
intentions and the patient's trust are assumed and do not need to be documented in writing.

The consent form that American ethical and legal theory finds indispensable for the protection of patient autonomy in medical decision making may be perceived in quite another light by NESPs whose cultures do not envision medicine in contractual terms. Rather than improving the relationship between patient and practitioner by enhancing patient independence, the consent form may erode the bond of trust on which that relationship must rely. Because it focuses on the risks of failure and appears to relieve the physician formally of all responsibility for such failure, a patient unfamiliar with the concept of consent may lose confidence in the physician's judgment and skills when presented unexpectedly with a consent form.8

If required to sign an untranslated and unexplained consent form, a NESP may worry both about the liability that it creates and overestimate the seriousness of the procedure for which the consent form was executed. Such anxiety can be detrimental to the short- and long-term outcome of treatment, especially if the patient's trust in the hospital and physician providing care has also been shaken. For this reason, if for no other, it is essential that the purpose of consent be explained fully to NESPs in their own language, and that competent translation be provided for reading and discussion of the consent document.
Where translators are not available, especially in the case of exotic languages, it is difficult to criticize a physician who does not obtain translation for NESPs. But when a hospital provides trained interpreters as part of its services, it is difficult to understand why physicians would not use them when obtaining consent from patients who do not speak English. As discussed previously, many staff members find it troublesome and time-consuming to use interpreters, and because many physicians view informed consent only as a guard against litigation, providing translation for NESPs' consent forms may appear to be unnecessary extra work. Yet where other, ethical motivations may fail, any suit-conscious physician should recognize that obtaining consent with a translator is good defensive medicine, as the presumption of disclosure created by the signed consent document is furthered by a record of oral disclosure possible only with translation.

Despite the study hospital's official commitment to providing translation for its NESPs, its medical staff routinely obtained NESPs' signatures on consent forms written in English without such translation. This practice underscores the basic flaw in the prevailing understanding of the principles of informed consent. In the current atmosphere, the consent form is a hollow shell, no longer a token of information given orally, but often the only information that the patient receives. Patients for whom
the consent process consists only of signing a form are victims of the legalistic attitude that makes the piece of paper more important than the act that it is intended to document. To patients who speak English, the unexplained consent form is often meaningless; for patients who do not, it is absurd.

Where consent is understood as an essential part of the decision-making process in which both patient and physician take responsibility for the treatment, the consent form is a symbol of the covenant between them. It represents a dedication to personal autonomy and the right to self-determination, and signifies that the physician has given the patient the information and assistance necessary to make a free and informed consent to treatment. For NESPs, translation is a vital part of this process, and translation of consent forms is the barest necessity for valid disclosure.

Translating NESPs' consent forms is nothing more than a legal minimum, however, unless such translation is part of an active campaign to overcome the obstacles to NESPs' active participation in treatment and the preservation of their dignity. English-speaking professionals can develop ethical therapeutic relationships with their NESPs only if they recognize that the personal respect demanded in such a relationship requires that each patient be treated as an individual with particular needs. For the caregiver to meet
the needs of the typical NESP and to be true to the ethical demands of contemporary health care, the structure of their personal encounter must be radically transformed; the professional must involve an intermediary -- an interpreter -- in almost every phase of care.

Communicating with NESPs Through Translation

In the international literature on the problems caused by language barriers between patients and their caregivers, the role of the interpreter in facilitating their communication has received scattered attention from a variety of health care professionals. It is unfortunate that the NESPs interviewed in this study seldom reported having talked with staff members through an interpreter, as few solid conclusions can be drawn from the surveys about the effects of translation on patient perceptions and understanding, or on patient-caregiver relationships themselves. However, a number of observations common to the literature on interpreters in clinical settings do apply to the findings of this study, and several works raise ethical issues which the study results also suggest to be crucial to NESP care.

Four types of translators are commonly used in medical settings: 1) skilled medical interpreters; 2) bilingual health care professionals; 3) bilingual lay staff; and 4) bilingual patients, family members, and other visitors [Abraham; 1988a; Bal, 1981; Diaz-Duque, 1982; Faust &
Drickey, 1986; Kohut, 1975; Marcos, 1979; Putsch, 1985; Websdale, 1982]. Most of the researchers and clinicians who have studied the use of medical translation acknowledge that trained medical interpreters are unavailable in most clinics and hospitals, and that many caregivers frequently rely on bilingual lay staff, patients' family members, and other, bilingual patients to communicate with their NESPs [Abraham, 1988a; Bal, 1981; Diaz-Duque, 1982; Fitzgerald, 1988; Marcos, 1979; Putsch, 1985; Websdale, 1982]. Despite their recognition that untrained bilingual staff and visitors are more readily available than skilled interpreters, and that they are certainly better than no translator at all, these authors unanimously conclude there are serious -- and even dangerous -- drawbacks to having lay people act as intermediaries in any therapeutic encounter.

Lay people as translators: practical and ethical concerns

Clearly, the most obvious problem is that not everyone who appears to be bilingual has the language skills to provide accurate translation. Someone who speaks good conversational English may not be able to follow a discussion of medical problems, and conversely, fluency in the NESP's language does not necessarily imply knowledge of medical terms that the patient will recognize [Abraham, 1988a; Bal, 1981; Diaz-Duque, 1982; Faust & Drickey, 1986; Grasska & McFarland, 1982; Marcos, 1979; Putsch, 1985; Websdale, 1982]. A translator who does not fully understand
the message to be conveyed, and who may be embarrassed to ask for a fuller explanation or admit to ignorance, may seriously distort important exchanges.

In keeping with these conclusions, the present study found that hospital staff members called on persons from each of these 4 categories to act as translators, but that although official interpreters might have been available, family members and bilingual medical staff were usually asked to translate because they were closer at hand. A number of the NESP's family members who translated for their relatives were not truly proficient in English, and some of the staff who served as translators spoke less than fluent Spanish. Although the ultimate success of their translation cannot be determined, it is quite likely that the quality of this communication was not good, and that the caregivers were largely unaware that their messages were distorted.

Just as important, there are problems inherent in using family members, friends, and other patients to communicate with NESP's which go beyond their fluency in English or knowledge of specialized vocabulary. Persons close to the patient may be unable to provide accurate translation because personal involvement in the case colors their understanding of what each party says. They may attach special significance to particular statements or questions, omitting or emphasizing information according to their own interpretation of its importance, or adding explanations
that may be unrelated to the actual message to be translated [Bal, 1981; Grasska & McFarland, 1982; Marcos, 1979; Putsch, 1985; van Eys, 1986]. At other times, the translator may critique the caregiver's comments as he or she translates them or express disapproval of the patient's remarks to the caregiver [Grasska & McFarland, 1982; Marcos, 1979; Putsch, 1985]. In some instances the family member may not translate the caregiver's questions or comments at all, but respond to them directly according to his or her own knowledge and opinion of the patient's situation [Marcos, 1979; Putsch, 1985]. Because the translator is the only one who understands both languages, and because this behavior is largely unconscious, it is hard for the caregiver to recognize or control such distortions.

The results of the present study's patient interviews suggest that translation by family members may have been subject to at least some of these effects. In particular, a number of the NESPs whose physicians claimed to speak to them through a translating family member reported that their doctors talked only to the family member, a finding which suggests that little actual translation occurred. This conclusion is supported by the fact that many of the NESPs whose family members were directly involved in talking with their caregivers were much less aware of their conditions and understood less about their treatment than other NESPs. Instead of facilitating communication between NESPs and the
staff, English-speaking family members appeared to have inhibited their already limited interaction.

Involving relatives in discussions between patients and their caregivers also creates serious problems for confidentiality, trust, relationships between caregivers, patients, and family members, and the validity of consent. Although some patients may want their family involved in every step of their care, others may be embarrassed, ashamed, or simply unwilling to share intimate details of their physical symptoms with even their spouses or siblings. Caregivers may commit a serious breach of patient confidentiality when they involve a family member in a NESP's care as a translator, especially because they cannot inquire whether the patient objects to having the relative translate without the same potential for conflict. Patients have been found to lie or withhold important information rather than reveal personal secrets to an unsuspecting relative or friend, and their embarrassment may turn to resentment and mistrust of the caregiver who put them in such an uncomfortable position [Bal, 1981; Diaz-Duque, 1982; Faust & Drickey, 1986; Putsch, 1985].

Being asked to translate personal questions or bad news may also place the bilingual family member or friend in an extremely difficult situation. Bilingual children or young adults, often a family's only English-speaking members, may feel themselves to be disrespectful when translating
questions or admonitions from their older relatives' caregivers. They, too, may withhold information from both patient and staff member in order to avoid betraying their vision of the behavior required of them [Bal, 1981; Faust & Drickey, 1986; Murillo, 1976]. The family member who unwittingly becomes the bearer of bad news may also be overcome by guilt for the patient's resulting anger or depression [van Eys, 1986]. These negative feelings may also be reflected back on the caregiver, diminishing the family's confidence in him or her.

By pressing family members to translate, caregivers may disrupt family relationships, likely already strained by the patient's illness. At times, especially in the case of serious illness, the patient may appreciate the family member's willingness to assume the responsibility of talking with the staff member; in many cultures it is the specific role of the patient's family to do so [Janszen, 1978]. Within the Mexican-American culture in particular, it is important for an individual to consult family members whenever he or she faces major medical decisions [Johnson, 1964; Schreiber & Homlak, 1981]. But the patient may also resent being cut out of his or her own care if family members called upon to translate take over. Such feelings sometimes lead to open disagreement, but more commonly patients remain silent for fear that conflict will cost them the support of family members and the respect of caregivers.
The subsequent tension may be extremely destructive to both the family's stability and, because it is often misinterpreted by caregivers, to the relationship between the patient and staff members.

Caregivers who seek to guarantee their NESPs' rights to informed consent by having their conversations translated may actually compromise the patient's access to information and freedom of choice if family members are used as translators. Family members may make choices for the patient without either the patient or caregiver being aware, much the same way that they shape the information that they translate according to their own interpretation of its significance. Often they make the patient's decisions with the same benevolent intent that can motivate professionals' paternalistic behavior: family members assume that they share the patient's values and know what is in his or her best interests. Like paternalistic caregivers, family members may withhold the information necessary for patients to make choices, provide only the information which supports their own perspectives, or present decisions as faits accomplis, completely circumventing the caregiver's efforts to engage the patient actively in his or her own treatment.

In some cases family members may believe that their knowledge of English, greater familiarity with the hospital and physician, and better understanding of clinical data makes them better equipped than the patient to make medical
decisions. These beliefs are reinforced by cultural assumptions about the inability of certain groups, such as women, younger adults, and the elderly, to make appropriate choices. Often the more important the decision at hand, the greater the likelihood that the patient's choice will be influenced by the translating family member. Even when the patient must consent formally by signing an informed consent document, family members may still impose their own choices by simply misrepresenting the nature of the form instead of translating it accurately.

The limiting effects of family members' translation on NESPs' ability to make informed choices was demonstrated several times in the present study. Three patients, whose bilingual family members had been quite active in translating for and communicating with the staff, underwent procedures which required them to sign an informed consent document. In each case, the consent forms had been signed by family members in the space for the translator's signature, yet none of the 3 patients understood the procedures that they underwent or why they were performed; these NESPs knew less about their care than many of whose staff members spoke to them only in the simplest English. They were clearly not active participants in their care, irrespective of their caregivers' desire to provide them with sufficient information to make free choices, because family members were allowed, or perhaps even encouraged, to
mediate their communication with the staff.

In addition to relying on the NESP's family and friends to translate, or when such persons are not available, caregivers often call upon bilingual lay hospital staff and even other patients' visitors to translate for them. Caregivers who ask hospital visitors to translate for their NESPs confer authority and knowledge upon a largely unknown persons in what in any other situation would be considered an intolerable breach of confidentiality. Often the NESP in question is not consulted about the choice of translator, and moreover, the visitor may feel that he or she must honor the staff's request for help to ensure that they continue to give adequate attention to the patient whom the visitor has come to see.

Asking such visitors to serve as translators involves many of the same problems as using family members, and often compounds them: it is almost impossible to know how well the visitor speaks the patient's language; impossible to predict how he or she will react to the patient as a person and whether that reaction will affect the information transmitted; and quite likely that the patient's interests will not be his or her foremost concern. Most importantly, because much translation involves highly personal matters, both the patient and the translator may be too embarrassed to communicate well. One nurse in the study recalled asking the wife of another patient to translate instructions for
wound care to a man who had been shot in the thigh. Upon reflection the nurse realized that the woman and the patient had been embarrassed by the man's semi-naked state and the nature of the information that she was asked to translate; the patient said almost nothing during the exchange, and it is likely that the woman's translation was not as complete or accurate as the nurse would have wanted.

Caregivers often turn to the hospital's clerical, housekeeping, and dietary personnel for translation assistance because, as employees of the institution, they are both easily available and generally accountable to the professional staff. Again, the drawbacks to using such persons as translators include their unknown proficiency in the patient's language; the likelihood that the information that they transmit will be inappropriately influenced by subjective judgments about the patient as a person; and the patient's potentially negative response to an outsider being included in his or her care. Like patients' relatives and friends, hospital employees known to be bilingual may feel that they cannot turn down a doctor or nurse's request for translation assistance because refusal might jeopardize their jobs; their reluctance and resentment is likely to be transferred to the patients for whom they translate, adversely affecting their interaction.

Moreover, some lay personnel who serve as translators may assume that their work gives them a certain medical
authority that can distort their translations and affect their other contact with NESPs. An uneducated Hispanic housekeeper on the obstetrics unit claimed that from her years of translating for new mothers and their caregivers she knew exactly what to tell the patients; she conducted her own "rounds" for NESPs and gave them advice on baby care before discharge even when not specifically requested to translate. The extent to which her advice corresponded to what these women would have been told by the staff had they spoken English was unclear, but none of the professional staff on the unit was aware of her practice.

The issue of the translator's background is especially important when, as in the case of foreigners who come to the U.S. for specialized care, the patient comes from a radically different socioeconomic status than the translator. Most housekeeping and dietary personnel are poorly educated and, especially in the case of second and third generation Mexican-Americans, tend to speak a highly informal, anglicized variation of Spanish. Although they may be able to communicate readily with NESPs of similar backgrounds, such translators may be incomprehensible to educated, foreign-born NESPs, who are likely to find their encounter frustrating and even insulting. Caregivers who are insensitive to NESPs' diverse backgrounds risk alienating their foreign patients if they treat them like working class immigrants. Conversely, well educated
interpreters must be able to use terms that uneducated patients can understand without patronizing them.

A number of the staff members interviewed in the study reported that they preferred to use medical staff and students or nurses as translators because they understood the presuppositions of medical interviewing. Clearly, a common clinical background makes bilingual health care professionals especially attractive to their colleagues as translators; in most cases the translator understands both the medical terminology that must be translated to the patient and the conceptual framework upon which the caregiver's questions and comments are based. Moreover, such translators share the ethical commitments of the therapeutic relationship.

However, there are serious practical limitations to using bilingual professionals as translators. Many institutions have few bilingual professional staff members, and their own responsibilities may not permit them the time to provide good translation for others' patients. One bilingual nurse interviewed in the study remarked that she no longer went to other floors to translate because her ability to speak Spanish had created such a demand that she had had too little time for her own patients. Moreover, if the medical or nursing staff do not make it clear to the NESF which person is in charge of his or her care, using another doctor or nurse to translate may confuse the
patient. As evidenced by the patient interviews, NESP's often conferred more authority on the physician or medical student who spoke Spanish than on the doctor for whom that person was ostensibly translating.

To overcome the substantial practical and ethical problems associated with providing adequate translation for NESP's, hospitals and clinics in communities with a significant NESP population need a full-time, trained interpreter staff. Professional medical interpreters should be fully bilingual, trained in the theory and methods of communicating with patients, and committed to the goals and standards of the ethical therapeutic relationship. Like other health care professionals in the hospital, the medical interpreter must be a highly trained, dedicated member of the health care team [Diaz-Duque, 1982; Faust & Drickey, 1986; Grasska & McFarland, 1982; Gremillion, 1984; Kaufert & Koolage, 1984; Kohut, 1975; Marcos, 1979; Putsch, 1985; van Eys, 1986; Websdale, 1982].

Extending the therapeutic relationship through interpreting

Ideally, the interpreter must have sufficient fluency in both the source and the target language to be capable of translating not only facts, concepts, and emotions, but also the nuances and unspoken messages which affect the overall meaning of an exchange. The importance of such abilities has been demonstrated by physician and medical ethicist Eric J. Cassell in a groundbreaking textbook on talking with
patients [Cassell, 1986]. Everything that the patient says reveals something about his or her understanding of the problem, and may be important to diagnosis and treatment. Similarly, the patient examines each of the caregiver's questions and comments for meaning and intent.

Cassell insists that health care professionals -- doctors in particular -- must master the logic of conversation and the subtleties of "paralanguage" to recognize the extent of a patient's desire for information and reassurance, how much information he or she can hear and understand, and what presuppositions affect the way that information is interpreted. As Cassell describes, the ability to perceive the meaning of a patient's choice of words, tone of voice, pauses, and words that remain unspoken is one which, demands specific training and dedication. Whereas good communication with most patients requires that the physician or other caregiver be able to discern these subtleties in English, the interpreters' task is to comprehend every syllable spoken by either party in either language, understand the meaning of the way in which it is said, and express the total message accurately in language that the patient or caregiver will understand as it was originally intended [Cassell, 1986; Diaz-Duque, 1982; Faust & Drickey, 1986; Putsch, 1985].

Interpreters also serve an important role as "culture brokers", providing explanations of foreign concepts to both
patients and caregivers [Faust & Drickey, 1986; Grasska & McFarland, 1982; Kaufert & Koolage, 1984; Putsch, 1985]. Because NESPs and health care personnel are often strangers culturally, even if the language barrier between them is overcome, the interpreter may often need to identify the patient's beliefs for the caretaker, and translate questions, explanations, and recommendations predicated on the worldview of Western medicine into ones more consonant with the patient's own system. In this way, the interpreter can promote the mutual understanding on which a therapeutic relationship depends, and give both patient and caregiver important knowledge that can improve any future interaction.

Interpreters contribute significantly to the ethical dimensions of the patient-caregiver relationship by ensuring, where the other staff member cannot, that the patient is given sufficient information about his or her condition to make informed choices and to participate actively in care. Many interpreters understand themselves to be not simply the instruments of the health care professionals with whom they work, but also as advocates for the patients whose care they facilitate [Faust & Drickey, 1986; Grasska & McFarland, 1982; Kaufert & Koolage, 1984; Putsch, 1985]. As advocates they are in the difficult position of serving both the interests of the caregiver and the institution, and those of the patient.

While accurate translation requires that interpreters
adhere faithfully to the content of conversation and remain morally neutral in their choice of words, advocacy may require them to pursue questions that patients do not know to ask and assert their patients' values as well as translate their words. As in the case of other health care professionals who seek to promote their patients' interests, interpreters must guard against the tendency to judge patients' concerns from their own perspectives; moreover, because they are often the sole voice of patients who cannot speak for themselves, interpreters risk compromising their patients' values even more than other caregivers if their perceptions are inaccurate. As advocates, interpreters may also need to side with a patient against a caregiver if the latter disregards the patient's values or concerns.

Many health care professionals resent this intrusion into the content of their interaction with patients, and many prefer to limit the interpreter's role to direct linguistic translation [Faust & Drickey, 1986; Grasska & McFarland, 1982; Kaufert & Koolage, 1984; Putsch, 1985]. Two of the staff members interviewed in the present study were quite critical of patient representative/interpreters because they appeared to challenge the authority and clinical judgment of doctors and nurses by raising questions which neither the patients nor their caregivers had mentioned. Both expressed a preference for bilingual nursing personnel or lay staff as translators because they
could be counted on to limited their personal comments.

Staff members who perceive interpreters to be a threat to their authority, or who are unwilling to allow interpreters to explore the greater needs and values of the NESPWs for whom they translate, not only fail to understand the demands of ethical therapeutic relationships, they also risk failing in their own efforts to help such patients. In a relationship between strangers the caregiver cannot know the patient's values or presume to act in the patient's best interests until the patient has expressed his or her own view of those values and interests. Far from interfering with their relationship, the true advocate interpreter enhances the ability of English-speaking caregivers to achieve the level of communication necessary to know their NESPWs as individuals and to treat them with the dignity and respect that they deserve. The interpreter is as much an advocate for the relationship as for the patient, as it is only through that interaction that the patient's needs can be met.

However, the interpreter's role in ethical health care goes far beyond providing the formal means for caregivers to achieve good communication with their NESPWs to establishing a much more fundamental aspect of care. The interpreter is capable of providing human presence to NESPWs in a way which no English speaking person can: where others are silent, the interpreter has the power to create presence through speech.
In this sense, the interpreter's interaction with the patient is not simply contractually based advocacy, but more a covenental relationship based in compassion. Moreover, the interpreter brings not only his or her individual presence to the patient, but as the voice of other caregivers the interpreter makes them present to the patient as well, enhancing the covenental nature of their relationships. The presence of an interpreter makes it possible to meet the human needs of the patient as a person as well as to treat the physical ailments of the patient's body.

There are, of course, many for whom ethical arguments for good communication based on compassion and respect for the patient's personhood or autonomy are not sufficient motivation to engage trained interpreters to work with NESPs. Many hospitals, clinics, and individual health care professionals dismiss interpreters as being neither necessary nor particularly valuable in the treatment of NESPs' physical ills, and reject formal translation as cumbersome and too expensive to provide routinely. The large percentage of staff members in the present study who recognized no need to translate for NESPs, and the number of hospitals with significant NESP populations that employ no interpreters despite the JCHA directive, are testimony to the apathy toward the need for good communication with all patients. In this situation, a strong appeal to coercive
justice and the self-interest of health care institutions and professionals is necessary.

As discussed earlier, one strong incentive to provide at least limited translation is the considerable threat of litigation. It is in the best interests of physicians, and the institutions in which they work, to ensure that trained interpreters translate all formal disclosures and consent documents, as well as much of the day-to-day interaction between NESPs and their caregivers. By using only official hospital interpreters to obtain NESPs' consents, physicians can make certain that their disclosure statements are conveyed accurately, that their patients have no unanswered questions or objections, and that there are no grounds for litigation based on fraud or coercion. And, unlike the patient's family members and friends, who are likely to side with the patient in the event of a complaint, an interpreter employed by the institution or doctor has an interest in protecting the physician from litigation.

Moreover, while most U.S. statutory and case law makes it the sole responsibility of the attending physician to ensure that his or her patients give valid consent to treatment, recent efforts by some plaintiff's malpractice attorneys to extend this duty to hospitals have met with modest success [Holm, 1986]. They claim that hospitals are no longer simply physicians' collectives, but administrative entities in their own right which contract with patients
separately; as such, hospitals have separate and direct administrative duties to their patients. These attorneys argue that one such duty is for hospitals to guarantee that doctors obtain valid consent from patients before permitting that their facilities be used for treatment. While such an administrative duty is less compelling than the physician's individual professional duty, the recognition of such a responsibility under the law makes hospitals liable for damages in the event of a suit proving invalid consent.

Most Texas hospitals which provide interpreters do so as a service to their patients, not to their physicians. This philosophy is especially true of hospitals whose interpreters operate as part of a patient representative staff [Gremillion, 1987]. Coupled with the JCHA policy on the NESP's right to translation, such a practice would give substance to any future legal charge that hospitals have an administrative duty to provide translation for their NESPs, especially when the patient is asked to give formal consent to treatment. The inclusion of a line for a translator's signature on the hospital's consent forms -- such as appears on the forms used by the study hospital -- would further support a claim to such a duty.

Economic Incentives for Providing Translation:
Shorter Stays, Fewer Tests, Wealthy Foreign Patients

In addition to the negative incentives posed by the threat of litigation, positive financial incentives for
health care professionals to use trained interpreters exist in almost every setting in which NESPs receive treatment. First, since 1979, the federal government has recognized that interpreting is an essential, reimbursable health-related service for NESPs. Medicare's language-related health policy allows institutions to include interpreter services -- including the costs of recruiting and training bilingual employees and translating health related materials, among their operational costs [U.S. DHEW HCFA, 1979; U.S. DHEW SSA, 1979; U.S. HEW ORR, 1980; Putsch, 1985]. Thus, the cost of implementing interpreter services should be relatively low for institutions which serve a Medicare patient population.

Moreover, a few hospitals in Houston have discovered that an interpreter service is an important drawing card for wealthy foreigners who want the best medical care that money can buy and who are fascinated by American technology. As health insurance is relatively uncommon outside of North America and Europe, these patients pay cash for their care, either in advance or as bills are incurred. The income that a doctor or hospital can generate from foreign, cash-paying NESPs makes the availability and use of interpreters to facilitate their care a profitable investment in public relations.¹⁴

The most significant financial incentive for employing medical interpreters, however, stems from indications that
the length of time that NESPs remain in the hospital may be protracted by their inability to communicate with the staff. In an era when hospital stays are being cut back for all but the best insured patients, institutional interpreter services may have significant appeal if they can reduce NESPs' lengths of stay per admission.

Length of hospitalization and the ability to speak English

From the outset of the investigation, it was suspected that there might be a difference in the length of time that NESPs and ESPs remained in the hospital, and that the difference could be attributed to the NESPs' inability to communicate with their caregivers. Whether NESPs' stays would be longer or shorter than ESPs' was unclear, as the literature on medical communication suggests that a language barrier between a hospital patient and staff members might lead to either outcome.

Textbooks on medical interviewing indicate that a NESP might have a longer hospital stay than an ESP with a comparable problem because a language barrier hampers physicians' ability to take an adequate history and make an accurate diagnosis, thereby delaying the initiation of appropriate treatment [Cassell, 1985; Engel & Morgan, 1973]. Additionally, a language barrier makes it difficult for the staff to assess improvement in their patient's condition, so that a NESP might be kept for a longer period of observation before discharge than would be the case if he or she could
speak English. Moreover, surgical patients who are told what to expect postoperatively and who receive verbal encouragement from their physicians have been shown to recover significantly more quickly than patients who do not receive such communication [Egbert et al., 1966; Reynolds, 1978].

However, similar arguments suggest that because a language barrier may prevent the staff from identifying subtle problems or discovering complications which might otherwise require necessitate further inpatient treatment, NESPs would be discharged before similarly afflicted ESPs who could report their symptoms [Cassell, 1985; Engel & Morgan, 1973]. In addition, patients who are unable to communicate well are often labeled as "troublesome" by the staff, who are inclined (whether consciously or unconsciously) to discount such patients' valid complaints. It has also been suggested that physicians might seek to discharge such "troublesome" patients as early as possible to be rid of the annoyance and extra work that they seem to create [Anstett, 1980; Gorlin & Zucker, 1983; Harmuth, Lantz & Oden, 1961; Stockwell, 1972].

Beside the effects of poor communication, economic factors would also seem to play an important role in shortening a NESP's hospital stay. A significant number of NESPs have no insurance or rely on Medicare or Medicaid for hospital coverage [Treviño & Moss, 1984]. In general, the
medical and nursing staff is aware of the extent of patient's insurance coverage; they may feel pressured to transfer or discharge uninsured patients as soon as possible [Ansell & Schiff, 1987; Gage & Andrusis, 1987; Schiff, Ansell, & Schlosser, 1986]. Hospital personnel in institutions where a large number of NESP are treated often associate a patient's inability to speak English with an inability to pay for care, and consequently many NESP may be discharged early on such grounds irrespective of their actual financial status [Treviño, 1986].

The federal Diagnosis Related Group (DRG) restrictions which were intended to control Medicare expenses have also created financial incentives for hospitals to discharge patients covered by federal programs earlier than they might release others with similar conditions [Anonymous, 1986c]. In an effort to prevent inappropriately early discharges, Medicare administrators have issued a letter to patients describing the DRG system and offering guidelines on how to appeal a premature discharge; this letter must be provided by the hospital to Medicare patients upon admission. A Spanish version of the letter is also available in the Southwest\(^{15}\), reflecting the number of NESP affected by this phenomenon [U.S. DHHS, 1986].

In an effort to determine whether any difference exists between NESP's and ESP's lengths of hospitalization, the study included a review of the medical records of all of the
adult Hispanic patients admitted to the study hospital during October 1985. The patients' actual lengths of stay were obtained from the face sheet of their individual charts, and each patient's DRG classification for that admission was obtained from the hospital's central medical records computer files.

The DRG classification system has been used by the federal government since October 1984 to determine the rate of reimbursement for hospital services received by Medicare patients. Payment is allocated according to the average total cost of care for the average length of stay for each of 416 diagnostic categories. The diagnostic categories are defined according to both actual diagnosis and procedures performed; all possible medical conditions fall into one of the 416 groups [U.S. DHHS, 1985].

Because of the small number of patients in this study, and the diversity of their diagnoses, it was not possible to compare their lengths of stay directly. Instead, the DRG allotted length of stay for each patient was used as a standard against which to measure his or her actual length of hospitalization. The difference between the mean length of stay and the mean DRG allocation was determined for the NESPs and ESPs as groups, and the difference between their mean DRG allocation and mean actual stay were then compared.

Among the 46 matched subjects (23 ESPs, 23 NESPs), the
average length of stay for ESPs was .2 days less than the average DRG allotment, while the average NESP length of stay was 1.2 days greater than the average DRG allotment. Although the diagnoses of the patients in these two groups were similar, and the standard deviation for the difference in their stays was relatively small, the total number of patients was not large enough to produce a statistically significant comparison between the groups.

The total subject population (52 ESPs, 25 NESP) demonstrates a somewhat more significant difference, both within each group and between the two. The average ESP length of stay was 1.0 day less than their average DRG allocation, a figure which is statistically significant (p<.05, 5.1 df). The average NESP length of stay was 1.1 days greater than their average DRG allocation. Although this figure itself is not statistically significant, the variation between the differences of the ESPs' and NESP's length of stay and their respective DRG allotments does approach statistical significance.

Figures for the entire population of adult Hispanic patients admitted during the study month (excluding all but one of the patients who did not survive to be discharged), while more significant than for either smaller subject group, still fall just short of statistical significance. The average ESP length of stay was .4 days less than the DRG allocation. The average length of stay for the total
surviving NESP population was again 1.1 days more than the average DRG allocation.

Language's influences on length of stay

Because only one segment of this study demonstrated a significant difference between patients' length of stay and their respective DRG allocations, this study is ultimately inconclusive on the question of whether patients' English-speaking ability affects their length of hospitalization. Nonetheless, a steady increase in significance accompanied the rise in population size, suggesting that a sample larger than the small groups studied here might demonstrate a statistical difference.

In addition, a study population with a more limited set of diagnoses (e.g. all obstetric or all internal medicine patients) might result in a smaller standard deviation. There were a number of long-term orthopedic and ICU patients in each group whose lengthy stays were responsible for large standard deviations among the groups of less seriously ill patients. It is even possible that there would be different results for patients on different services, which a comparison of more internally consistent groups of patients could demonstrate.

To date no other work has examined the specific effects of a patient's ability to communicate with caregivers on his or her length of hospitalization, although public health research on hospital use suggests that such a study could be
quite revealing. A recent federal survey of hospitalization among members of different races and ethnic groups indicates indirectly that a patient's inability to speak English might lengthen his or her hospital stay. The 1984 National Health Interview Survey conducted by the U.S. Department of Health and Human Services' (DHHS) National Center for Health Statistics determined that the average hospital stay for the total American population, the basis of the DRG allocation system, is 7.2 days. However, the total Hispanic population averages stays of 6.5 days, while Mexican-Americans, counted separately, average 5.3 days per hospitalization [Moss, 1986].

These figures are not adjusted for age, and because the Mexican American population is younger than the population as whole, their comparable, age-adjusted average would be closer to 6 days of hospitalization per admission [Moss, 1986]. The resulting -1.2 days difference between the average of the American population as a whole and the average of Mexican-Americans reported by the DHHS corresponds to the present study's finding that English-speaking Hispanic patients (almost all of whom were Mexican-Americans) spend roughly a day less per hospital admission than their corresponding DRG allotment.

However, a comparison between the the DHHS statistics and the present study's figures for NESPs demonstrates an interesting paradox: the NESPs were also almost all Mexican-
Americans, yet their average stay was approximately one day longer than their corresponding DRG allotments. When combined with the DHHS's -1.2 day difference between the average length of stay for Mexican-Americans and the average of the total American population, the NESP's figures are quite striking. The NESP's in this study spent approximately 2 days longer in the hospital per admission than the national average for Mexican-Americans.

What is responsible for the NESP's longer hospitalizations? The federal study provides no breakdown of Hispanics by primary language, and it is not known what percentage of the Hispanics included in the DHHS figures speak only Spanish. However, 1980 census figures indicate that roughly only 20% of the U.S. Hispanic population speaks little or no English; even considering undocumented Spanish speaking Hispanics, the number is likely to remain under 30% [U.S. Senate, 1985]. If the DHHS' sample is truly representative, the ability to speak English may be one of the most consistent differences between the present study's NESP population and the Mexican-American population as a whole, and the language barrier would be appear to be the basis of the longer stays.

Two extra days of hospitalization for the roughly 800 Hispanic NESP's admitted to the study hospital in 1985 amounts to an additional annual expenditure of more than $1,200,000.18 This figure does not include the costs of
caring for pediatric or non-Hispanic NESP's, which could easily bring the cost to $2,000,000. National figures, while difficult to estimate because of the paucity of information about patient language, would be quite alarming. Given the high percentage of NESP's who have no health insurance or who are covered only by Medicare or Medicaid, the burden of such extra expenses would fall especially heavily upon public and charity institutions, and government health care budgets at all levels.

If NESP's longer hospital stays are indeed the result of the language barrier between them and the staff, employing several skilled medical interpreters and training hospital personnel in other languages common in the community could be a significant cost-cutting step for individual hospitals, local governments, and state and private insurers. In addition to shortening NESP's stay by improving their communication with staff generally, using interpreters to take detailed histories might curb physicians' tendency to order expensive, and sometimes unreimbursed, diagnostic tests because information cannot be obtained directly from the patient [Cassell, 1985; Poma, 1985]. Moreover, using interpreters to explain postdischarge self-care to NESP's may result in better compliance with treatment recommendations, quicker recovery, and fewer readmissions [Ley, 1983].

If it can be established that a patient's inability to
speak English lengthens his or her stay, the specific causes of that effect must be identified. The factors which counteract the recognized effects of economic "dumping" and early discharges for "troublesome patients" must be quite powerful [Treviño, 1986]. It would be especially important to determine whether there might be specific aspects of communication -- such as the physician's ability to take a thorough history, that are more important than others in this area.

Although we must address the broad issue of NESPs' longer hospitalizations as a problem of cost containment, the individual events which might contribute to longer stays may also create other significant costs to the hospital and the community. If NESPs' diagnoses are delayed because of a language barrier, it must be determined whether they are put at undue risk before appropriate therapy is initiated, making full recovery slower and more expensive. If treatment is begun based on inaccurate diagnoses because it is impossible to take a complete history, the extent to which NESPs are put at risk for the complications of inappropriate intervention must be ascertained and those costs minimized. Where improvement cannot be assessed effectively, complications are likely to be equally difficult to recognize; NESPs are likely to be discharged with unvoiced, unidentified, and untreated symptoms or underlying disease which may lead to future hospitalization,
lost wages, disability, unemployment, or death.

Health care professionals who are truly dedicated to their patients' best interests should be concerned to provide them with the most effective care possible, and above all to limit the risk of inappropriate intervention. In the case of NESP, providing such care necessarily includes using an interpreter. But this standard not only creates obligations to individual patients, it also relates to demands of social justice. In the American health care system, persons who cannot afford to pay for their own health care have very limited rights to certain minimum levels of hospital care provided at society's expense. The funds that are allocated to cover the needs of such persons are too meager to serve all who need them, and are much too limited to waste on unnecessary delays, inappropriate treatments, and readmissions. As many of the NESP across the country depend on the medical care provided by community resources, it is imperative that all measures be taken to ensure that the money spent on their treatment is spent judiciously. Again, interpreters can make an important difference.

There are few occasions in health care when the needs of the individual and the needs of society merge rather than conflict. The issue of medical translation and good communication for NESP is one area in which the goals of personal care and financial austerity demand identical
action. Health care professionals who provide interpreting for NESP's both demonstrate respect for their personal dignity and right to free and informed consent to treatment, and help to meet the demands of distributive justice that require scarce and limited resources to be allocated fairly among those in need. When medical interpreters are used to their fullest potential, everyone benefits.

Notes to Chapter 5

1. The study hospital attempts to identify the charts of all NESP's by marking their chart imprint cards (plastic cards similar to credit cards, with which every sheet of paper placed in a patient's chart must be stamped) with "/NES" after the patient's name. In some cases, an abbreviation of the patient's language is also included (eg. /NES SPAN). However, only those patients who are admitted at the main Admissions office receive the special cards, and even some NESP's who do come through Admissions are not identified as such.

Of the 66 NESP's admitted in October, 1985, only 18 (27%) received "/NES" stamp cards. Of the 25 NESP subjects, 4 had neither the card nor any other indication of their language status. Several of the remaining NESP's had no indication of their language status in their charts; those who were not contacted were identified as NESP's in charts from earlier or later admissions, or where there was a strong suspicion that they spoke no English, by caregivers who were contacted for that information.

There was no consistency to which of the many staff members noted the patient's language in the chart. Although the nursing assessment form included a space for special considerations and a check-off list for patient orientation to the unit, nursing comments about patients' language were irregular.

2. In one case the patient was a Jehovah's witness who had requested bloodless surgery. In another the patient had broken several ribs and his doctor wanted to explain how important it was for him to cough after surgery, despite
the pain that it caused. In 3 other cases, nurses on the obstetric service gave baby care instructions to first time mothers, using their husbands as interpreters.

3. A 42nd NESP was not competent to give consent at the time of his surgery. He had no family, and his surgeon signed the consent form.

4. In addition to the patient representatives, a small number of bilingual staff members from other positions have been certified as medical interpreters by the hospital. These persons are volunteers who do translations in addition to their regular assignments without additional pay. They must pass a standardized translation exam and complete a probationary period in which they are observed at work. One of the nurses who signed a consent form as the translator was a volunteer interpreter. One of the other staff members who had signed as having translated a consent form had applied to be certified, but had been rejected because of his poor Spanish.

5. The names of 6 unidentified persons who signed as translators were referred to the patient representatives; they were able to identify 3 as staff members. The remaining 3 were not identified by the hospital's personnel office and are assumed to have been family or friends of the patients. No one was able to decipher the 2 illegible signatures.

6. Unfortunately, it is impossible to tell who actually presented the consent forms to the patients. Attending physicians seldom obtain signatures on consent forms, although they are ultimately responsible for the consent's validity and may provide the patient with discussion of the intended procedure. Often, a resident or nurse asks the patient to sign the consent document itself.

7. One result of the current movement to make English the "official" language of the United States by state-by-state referendum would be to make the English consent form the only required, and only valid, consent document, effectively denying NESPs true informed consent, despite broader laws governing disclosure [Anonymous, 1986a; Kimball, 1988].

8. This phenomenon is not limited to patients who do not speak English or who come from other cultures. One of physicians' most frequent complaints about informed consent is that the disclosure of risks scares patients
away from treatments that they need, and that it causes many to doubt or ignore their doctors' advice.

9. I interviewed this woman informally after she approached me about my study. She was cleaning the room of a NESP about to be discharged when I came in to interview the patient, and was very interested in my questions and the patient's answers. She was clearly very proud of her work as a translator and very concerned about the wellbeing of the young mothers whom she called her patients.

10. A patient whom I met a few months before the study complained vigorously that everyone in the hospital treated her like a "dumb Mexican peasant" just because she spoke Spanish. She was, in fact, a well educated member of a very rich and politically powerful family who had come to Houston for treatment of a gynecological cancer. One of her principal objections was that the Hispanic nurse's aide who translated for her doctor and nurses used vulgar terms for her reproductive organs, ostensibly because she did not know their correct names in Spanish.

11. The role of "paralanguage" in all communication is an important reason why the prescribed diagnostic questions and task-oriented questions presented in English and the target language by medical translation guidebooks is unlikely to achieve little true communication [Anonymous, 1980; 1984b; Hirschhorn, 1968; Kantrowitz, Mondragon, & Coleman, 1978; Karpeles & Gorin, 1983; Teed, Raley, & Barber, 1983]. Not only is it unlikely that the patient will stick to the limited choices offered by such guides' prefabricated dialogue, because the guidebook's user does not truly know what he or she is saying, the paralanguage of pronunciation, rhythm and pauses, and inflection may give the patient terrible misuses about what is really being asked.

12. The Grasska and McFarland article and the Putsch article strongly oppose interpreters as advocates, and cautioned that interpreters who interject their own questions or comments either to the patient or the caregiver for whom they translated only distracted everyone from the point of the interview. Grasska is a nurse, and Putsch is a physician. The two other articles, one written by a pair of social scientists, the other by a nurse practitioner and family practice physician are strongly in favor of interpreters acting independently.

13. For example, neither of Houston's public hospitals employs medical interpreters, although their NESP
population reaches 30% of their patient load.

14. The solicitation of wealthy foreign patients is a practice which raises a number of ethical issues. Primary among them is the fact that bringing such patients and their money to the United States further impoverishes their own health care systems, both from a financial perspective and in terms of the experience that health care professionals in those countries could gain from treating such patients. Although the patient drain from developing countries is not as big a problem as the physician "brain drain", it does contribute to a wider gap between what the United States and developing nations have to offer in health care.

15. The Spanish letter is typical of documents provided in Spanish by hospitals and other health care institutions -- it is rife with errors.

16. The DRG allocated lengths of stay are reported in tenths of a day, while the hospital medical records computer file gives length of stay only to the nearest full day. This variation is not important for the purposes of this study, as it the difference between the DRG allocation and the actual length of stay which is compared between the groups; this difference is not affected by varying methods of reporting where each method is consistent.

17. The patient included here suffered a respiratory arrest and died as he was being discharged.

18. According to officials in the business office at the study hospital, the average daily cost for a surgical patient in October 1985 was $900; for an internal medicine patient, $700; and for an obstetric patient, $600. Based on a breakdown of patient services for the 66 NESPs admitted during that month, the average daily cost for hospital care is $790. The yearly cost of caring for 66 NESPs/month for 2 extra days at $790/day, is $1,251,360.

The hospital in the study did have a paid staff of 3 full-time patient representative/interpreters and 1 part-time interpreter at the time that this research was conducted. However, very few of the subjects interviewed reported having had contact with them, and few staff members calling them regularly for assistance. The mere existence of an interpreter service, therefore, would not necessarily result in savings to the hospital. An effective program to convince medical personnel of the overall value of professional medical interpreting, and to teach them to use interpreters' skills most effectively, would be necessary to integrate
interpreters into the health care team before the greatest possible economic benefit could be realized.
Chapter 6
Epilogue
Teaching Patients to Speak for Themselves

In a number of ethical systems, a fundamental criterion for assessing the behavior of individuals and institutions is how their treatment of the weakest and least advantaged members of their community compares to the recognized norm. Similarly, the strength of ethical commitments is revealed when practical obstacles make them difficult to keep. The impersonal treatment that health care professionals provide to patients unable to speak English -- patients who are often socially disadvantaged and who present a significant challenge to caregivers' communication skills -- belies the contemporary standards of covenantal and contractual health care.

The experience of the NESP's in this study confirms the ethical theory that good patient-caregiver communication is essential to preserving patients' autonomy and providing them with compassionate human presence. Yet NESP's isolation from caregivers and dependence upon them illustrate that neither current commitments to professional presence or patient self-determination, nor existing legal requirements intended to guarantee patient rights, are sufficient to overcome practical obstacles to providing ethical care. Not only was the interaction between NESP's
and caregivers too limited to permit patients to participate actively in treatment, almost half were denied even the basic disclosures to which they were entitled under law.

Much of the discrepancy between contemporary ethical standards for patient-caregiver communication and what actually takes place in many encounters is due to the fact that the standards are new and revolutionary, and were in part imposed upon health care from the outside. Moreover, ethical theory on the therapeutic relationship has not been free of controversy itself, as testified by the varied interpretations of informed consent and its demands. Even where theorists agree on the need for free and open communication in health care, proponents of both contractual negotiation and professional presence often fail to recognize that neither can inspire and support ethical therapeutic relationships alone. Analogous to Reinhold Neibuhr's vision of democracy, caregivers' acceptance of informed consent is possible because of the human capacity for compassion, but necessary because of the human tendency toward self-interest and unwarranted paternalism. In health care as in all human endeavors, efforts to achieve ethical goals must be both grounded in structures of justice and upheld by a dedication to virtue that fulfills and transcends those formal structures; respect for patients' autonomy and compassion for their suffering are not contradictory but complementary and mutually sustaining.
A final examination of the NESP interviews reveals a perspective on the therapeutic relationship that helps to explain the inadequacies of both autonomy and presence as they are commonly understood. The NESP's vision of the therapeutic relationship calls into question current assumptions about patient-caregiver interaction, and suggests that contemporary ethical presuppositions not only support professionals' ambivalence toward patients with whom it is difficult to communicate, but also have important, and often unrecognized, effects on their relationships with other patients. Reflection on how these assumptions affected many of the NESP's illustrates the full dimensions of why and how caregivers must talk with their patients, and points to an expanded role for health care professionals who are truly dedicated to their patients' wellbeing.

Negotiating with a silent partner: autonomy, informed consent, and the unempowered patient

As discussed in the introductory chapter, the foundation of contemporary moral theory about the therapeutic relationship is the assumption that adult patients are self-determining persons with their own interests. Based on this presupposition, a central thrust of modern medical ethics has been to insist that professionals recognize and respect their patients' autonomy and personal values. Perhaps more than that of any other contemporary ethicist, Engelhardt's work on the issues of
pluralism and transitory therapeutic relationships has given practical currency to the theory of autonomy across the health care professions. As detailed earlier, Engelhardt insists that conflict over values and interests be identified and resolved through informed consent as a process of contractual negotiation in which both patient and caregiver present their views openly to the other [Engelhardt, 1982; 1986]. The more the patient and caregiver are strangers to each other, the greater is their need for negotiation and recognition of their autonomy and potentially divergent interests.

Because the patient may not understand the concept of informed consent, Engelhardt assigns to the caregiver the responsibility of spelling out the procedures for fair negotiation, ensuring that negotiation takes place, and assisting the patient in making decisions consonant with his or her own values. Despite the need for the caregiver's procedural advocacy, Engelhardt assumes that both the caregiver and the patient are motivated by self-interest, and that each will assert personal claims rather than accede to the judgments of the other without objection. He maintains that each holds a "moral trump" -- the freedom to leave a relationship in which no agreement can be reached -- which ensures that his or her values will not be compromised [Engelhardt, 1982].

The NESP in this study appeared to be the very sort of
patients for whom Engelhardt's negotiation would be essential: most were strangers not only to their caregivers, but also to the individual cultures and subcultures of the modern North American hospital. Yet, a number of the NESP's interviewed in this study demonstrated that even with their caregivers' encouragement and the availability of good translation, some patients will not express their interests or even needs in any immediately recognizable way. It is evident from the NESP interviews that there are many persons who are unwilling or unable to speak for themselves, and some for whom such negotiation in itself poses a serious moral conflict.

Despite the finding that the NESP's level of communication with their caregivers often failed to meet even the most basic ethical standards for disclosure, most expressed neither surprise nor displeasure that their only role in treatment was as the body that needed repair. The NESP's as a group reported much greater satisfaction with their caregivers' poor communication behavior than would have been predicted from other studies of patient satisfaction or the responses of their English-speaking counterparts. Moreover, a few reported satisfaction that was out of all proportion to the quality of their relationships judged by contemporary ethical standards.

Apart from vigorous discussion about competence and some sociological examination of the passivity that comes
with the sick role, the focus of contemporary ethics has been on patients who know their own interests but whose decision-making abilities are overwhelmed by their caregivers' paternalism. Little consideration has been given to the question of how patients see the importance of their own interests in treatment decisions. Given current definitions of informed consent, the NESPs' apparent disinterest in active participation makes it difficult to determine the demands of the caregiver's ethical duty to respect each patient's right to self-determination when the patient is unwilling to be self-determining.

Although the NESPs' inability to speak English was clearly a major factor in their passivity, they often remained silent even when excellent translation was available. This reaction can be explained in part by their expectations of the patient role itself. The majority of the NESPs had been treated in American hospitals previously, and it is likely that they expected little communication with English-speaking staff members because they had had little on those occasions. Moreover, most of the NESPs were immigrants whose interaction with health care personnel in their native medical systems was almost certainly dominated by the paternalism which continues to flourish in developing countries. A recent investigation of physicians' explanations to their patients conducted by the Mexican Ministry of Health revealed that Mexican doctors give their
patients virtually no information about their conditions or treatment, and allow them to ask almost no questions [Franco, 1987].

But the NESP's' almost universal satisfaction with their caregivers' behavior suggests not only that they had little expectation of communication with their caregivers, but also that they did not expect to be included in decision-making. They believed that it was the physicians' and nurses' job, not theirs, to know what needed to be done. Although these patients may have had questions, they did not raise them because they did not question the knowledge and authority of their caregivers. Although they may have had opinions about their conditions and care, they remained silent because they expected the staff to assume responsibility and control for every aspect of care.

In an ironic conflict of values, NESP's anticipated that their own personal interests would be of little consequence to their caregivers, whom they expected to limit rather than encourage their comments. Many denied outright any real need for information, and others' satisfaction with limited disclosures suggests that access to such information, too, was of little importance to them. Thus, these NESP's and patients like them pose a paradox to caregivers seeking to respect their patients' autonomy: the patient's specific interests need not even be determined in order to provide treatment consistent with the patient's values. Ironically,
the caregiver who honors professional commitments by seeking to engage such patients actively in treatment may appear to coerce them.

It is not surprising that even those staff members who did offer their NESPs information and choices did not pursue the matter when the patients refused disclosures, asked no questions, agreed readily to suggestions, or asked others to decide for them. The current definition of patient autonomy admits that the right to self-determination includes the right to abdicate the freedom to choose. Engelhardt in particular has suggested that a paternalistic relationship created by mutual choice is an ethical one [Engelhardt, 1986]; the NESPs' caregivers would be morally correct in assuming total control over their care because the patients wanted them to take that responsibility.

However, this paradox hinges on an understanding of autonomy which does not fully accommodate the complexities of the human response to choice. In one of the most thorough critiques of ethics' current emphasis on autonomy, psychiatrist and medical legal scholar Jay Katz has argued that ethicists who, like Engelhardt, focus only on the abstract Kantian approach to autonomy overlook the clinical realities of human incapacities to act "voluntarily" [Katz, 1984]. Psychiatry teaches us, rather, that every human being's autonomous behavior is shaped by both conscious, rational capacities for choice and unconscious, nonrational
reactions that make wholly rational choice impossible. Katz insists that any theoretical understanding of autonomy must accommodate this interrelationship, and recognize how such natural human experiences as illness can change the balance between reason and nonreason.

Katz's redefinition of autonomy separates the traditionally central action of making choices from a reflection about choices which must precede decision-making. For Katz, psychological autonomy has as much to do with the ability to think about choices as with actually choosing. Consequently, informed consent must be concerned not only with respecting patients' freedom to choose and their eventual choices, but also with respecting and enhancing their capacity for reflection about choices. In this context, procedural advocacy which simply provides patients with information and encourages them to make their own decisions is not enough. Respect for psychological autonomy requires that patients and their caregivers reflect upon and discuss the bases for their choices, in order to discover the unconscious misconceptions, magical thinking, unwarranted fears, and exaggerated hopes whose influence cannot be overcome by even the most detailed rational information.

Where Engelhardt maintains that health care professionals have the right to insist that their patients accept disclosures which the caregiver believes to be
essential to the patient's free choice\(^1\) [Engelhardt, 1986], Katz goes even further. Because psychological autonomy depends upon the ability to reflect, as well as on the availability of information, caregivers must ensure that patients understand the rational and nonrational reasons for their choices, and attempt to limit the influence of unconscious irrationality. In trying to respect patients' autonomy, caregivers must never accept their decisions at face value, but must engage them in in-depth conversation to draw out the full scope of their rationale.

Katz's vision of informed consent conflicts directly with the contractual claim made by Engelhardt and Veatch that the right to information and free choice does not carry an obligation to be informed or to make choices [Engelhardt, 1986; Veatch, 1981]. Where Engelhardt and Veatch contend that informed consent implies that patients may freely refuse information and choose to have others make choices for them, Katz maintains that the caregiver's duty to question the basis of a patient's decision is most pressing when the patient accepts the caregiver's recommendations unquestioningly and refuses the information necessary to make an enlightened choice. Where Engelhardt and Veatch assume that a patient's refusal of information and independent choice is itself an autonomous act, albeit for Veatch one that can be dehumanizing, Katz insists that such refusal is often the result of an unconscious fear of choice
which paralyzes true autonomy. Caregivers who take responsibility for their patients' choices in what Engelhardt and Veatch would accept as an autonomy-respecting contractual paternalism, are in Katz's view, too ready to treat their patients as children who cannot bear the burden of adult freedom.

Katz admits that many patients have conflicting feelings about themselves: they want to be treated both as children and as adults. Illness can create a desire to be cared for, comforted, and protected by a loving parent who will take responsibility for all of the difficult choices that illness entails, and many caregivers are happy to take such care of their patients. Yet, Katz argues, to recognize only a patient's childlike longings for absolute security denies the existence of the adult who both wants and deserves a voice in treatment decisions. To respect a patient's autonomy, caregivers must hear and recognize both the child and the adult within each person, and must ensure that the patient consciously distinguishes between their conflicting needs before making choices.

Katz's identification of the conflicts inherent in choice explains the responses of many of the study's NESP's. Nonetheless, a small group of NESP's raise even more complex questions about patient autonomy and the appropriate means of respecting it. For this group, the crucial element was ultimately neither the language barrier nor their
understanding of patienthood, nor their longing for security, but a more fundamental problem of self-perception. The nature of their self-image is clear from a comparison with ESPs from this and other studies. Across the literature on patient satisfaction, patients whose physicians gave them little information and few options were dissatisfied and even resentful of their doctors. They knew, instinctively if not intellectually, that their own perspectives and interests deserved attention and respect, and that they had some moral authority to determine their own futures. By contrast, none of these NESP's reported or displayed such a sentiment, even when they had no role whatsoever in determining how they would be treated.

Contemporary ethical theories on the therapeutic relationship are predicated on the conviction that, regardless of their social roles, all persons are equal in their right to self-determination. However, these NESP's did not share that view. They did not distinguish the staff members' professional authority from a greater moral authority, and they did not see themselves as their caregivers' equals in any sense. These patients assumed that it was unimportant to bring up their own opinions for discussion because they believed them to be unworthy of consideration. Despite their own competence and capacity for choice, even when these patients were presented with alternatives they did not think themselves fit to judge
them, and they placed the responsibility of decision-making back on the caregivers who had asked them to choose. Even when their own perceived interests conflicted with their caregivers' treatment decisions, they did not expect to have options, and were unwilling to challenge the choices made for them by the staff.

It is difficult to recognize the demands of an ethical therapeutic relationship with patients such as these NESPs, not only because respecting their values creates an inescapable paradox for current models, but more importantly because they do not share our assumptions about their autonomy. The freedom to choose upon which both contractual and covenantal relationships are based is meaningless to those who do not know themselves to be free. Even Katz's more complex definition of psychological autonomy is of little help, for patients who believe themselves to have no right to choose will be unable to reflect upon choices. A contractual relationship is impossible for patients who do not know themselves as the autonomous moral agents which contractual negotiation requires them to be. Similarly, a covenantal relationship rapidly dissolves into paternalism if one partner believes him or herself to be totally dependent upon the other.

Still more perplexing is the fact that some patients who do not recognize their own right to self-determination assign a negative moral value to self-assertion,
particularly against such authorities as physicians and nurses [Fitzgerald, 1988]. Poor Hispanics in particular come from a cultural and religious tradition that finds redemptive value in passive suffering, especially where ill health is believed to be a punishment for sin [Poma, 1979; Samora, 1961].² Often, even patients who recognize the necessity for choice will not make a decision without the approval of their father, older brother, or son, whose gender, age, and position in the family confers the specific moral authority that making such choices demands [Fitzgerald, 1988; Johnson, 1964; Murillo, 1976; Schreiber & Homiak, 1981].

Caregivers who would provide truly informed consent must question their patients' willingness to make uninformed, unconsidered decisions in order to determine the nature of the constraints on their autonomy. In some instances, the patient may be embarrassed to admit that he or she does not understand the caregiver's comments or questions, ashamed to ask questions that may appear stupid, or unwilling to risk wasting the staff member's time with discussion. In others, the patient may suffer from unconscious conflicts that make considered choices impossible. In still others, the patient may not recognize his or her freedom and ability to make choices, or moral authority to assert self-interest. Because the way in which caregivers must respond to their reticent patients depends
upon the reasons for the patients' silence, it is essential that the process of informed consent include discussion that can allow caregivers to discover not only their patients' conscious values and interests and their unconscious hopes and fears, but their more fundamental self-perception as well.

Engelhardt's procedural advocacy coupled with Katz's consciousness-raising reflection will likely ensure that the first two groups of patients make autonomous decisions. Yet, for the third group, neither procedural advocacy nor considered reflection on conflicting desires will resolve their unwillingness to choose. Patients who have no sense of their own autonomy will be unresponsive to procedural advocacy because it can only remove the obstacles to their self-determination, rather than foster self-determination itself. They will be unmoved by efforts to reconcile the childlike need for protection with an adult desire to retain control because even their conscious adult response is to avoid self-assertion. Informed consent, even as it is described by Katz, is not enough for these patients; access to freedom alone cannot ensure its realization.

Instead, their freedom to choose requires self-respect and a concept of basic human dignity that precedes psychological autonomy. In this vein, theological social ethicist James E. Sellers has drawn a parallel between informed consent for such patients and the civil rights
movement's empowerment of blacks in its campaign for voting rights [Sellers, 1986]. Sellers maintains that patients such as this small group of NESPs are part of a large "health care proletariat" who are unable to avail themselves of the liberty that informed consent seeks to ensure because they have no recognition of their own personhood. Such patients lack the ability or willingness to participate in their own health care because, in the words of Martin Luther King, they have no sense of "being somebody" [King, 1968]. Until they achieve "somebodyness", such patients can have no true freedom of choice.

Sellers notes that our society has invited the poor and powerless to think of themselves as passive recipients of minimum benefits which they are not permitted to judge. His observation is true not only in respect to the economic benefits of charity and government-funded health care, but also of the way in which health care professionals treat "proletarian" patients as individuals. In their willingness to assume that such patients freely choose to surrender their decision-making rights to others, many caregivers have succeeded in reinforcing these patients' conviction that they are incapable of self-assertion, thus denying them the very dignity which informed consent is intended to preserve.

The proletarian patient challenges the current understanding of ethical therapeutic relationships and the definition of how to treat patients justly and
compassionately. It is accepted that patients who are incompetent to choose need their caregivers to protect them and to make choices on their behalf; conversely, it is accepted that competent patients have the right to make their own choices, a right which, as contractualists insist, includes the freedom to choose to have their caregivers make decisions for them. However, proletarian patients, while not incompetent, are not empowered to assert their own best interests, and in refusing to make their own treatment decisions they do not freely elect to have their caregivers choose for them. What often passes as a legitimate contractual paternalism between such patients their caregivers violates the patients' right to respect as persons, despite their unawareness of their own personhood.

What such patients need is not the protection of paternalism, contractual or otherwise, but the liberation of self-realization. As Sellers concludes, before they can enjoy the benefits of liberty they need to recognize their "somebodyness", and experience the power that comes from self-assertion. To guarantee such patients' rights in any true sense, caregivers must seek to break the cycle of dependency fueled by their powerlessness. Because they recognize the intrinsic value and liberty of their powerless patients where the patients themselves do not, health care professionals have a responsibility to give their patients a sense of their own dignity, and to teach them what it means
to be "somebody".

The transformational power of teaching: the covenantal relationship as a force for self-realization

Such a process begins with the recognition that all patients must be treated with dignity, especially when they appear to question their own self-worth. This is not simply a procedural respect for moral autonomy, but a more fundamental acknowledgement of the value of every individual apart from the ability to reason or make choices. It must start with the dedicated practice of good communication, including many factors which patient studies have identified as being crucial to a good therapeutic encounter: courtesy, concern for the patient generally, an interest in the patient's specific complaints and an expressed willingness to listen to his or her opinions, and reassurance and support in dealing with the problem. Powerless patients will need considerable encouragement to talk with their caregivers in this way, as they are likely to have few if any expectations that such interaction could even occur. Moreover, their caregivers must be cautious that this approach not be interpreted as patronizing or mocking politeness.⁴ Patients who believe themselves and their opinions to be unworthy of health care professionals' attention may misinterpret sincere efforts to engage them in conversation.

Teaching patients bears a formal resemblance to
Engelhardt's description of informed consent in a contractual relationship, and involves the psychological consciousness-raising and reflection which Katz advocates. It requires that caregivers explain to patients that they have treatment options; solicit other options from them; ensure that they understand those options, their likely outcomes, and their greater significance; and recognize the impact of their nonrational reactions. Beyond this response to the patient as a social person, however, the caregiver must also address the issue of the patient's self-perception. Teaching looks beyond the procedural dimensions of contract and the analytical aspects of psychological therapy to the transforming relationship of covenant.

May has argued that teaching offers health care professionals one of the few ways in which they can transform their patients' health-related behaviors and attitudes without overriding their right to self-determination or ignoring their intelligence [May, 1983]. Caregivers who teach their patients need compassion and "moral imagination" to understand the patients' lives and perspectives, for they help their patients to transform their lives by seeing themselves in new ways. A good teacher empowers others with knowledge and understanding, and shares authority with them in exploring the subject being taught. Most importantly, May contends, teaching gives patients the freedom to behave in ways that they
previously believed impossible.

While May's intended focus is upon the teaching of specific behaviors that enhance recovery, prevent disease, and make it possible to cope with chronic illness, each of his claims for the transforming power of teaching holds true for the teaching that enables self-realization. Caregivers who would transform their powerless patients must have the compassion and moral imagination to recognize the trap of powerlessness, and to understand the suffering which it entails. They must help such patients to see themselves in a new way as persons with dignity who deserve respect. By empowering patients with knowledge, understanding, and authority over themselves, such caregivers can foster the "will-to-life" that May finds essential to the patient's participation in the therapeutic covenant [May, 1975].

Transformational teaching can give patients the freedom to make the choices that shape their lives, choices that they previously thought impossible. However, the true understanding of one's own personhood comes not from abstract knowledge, but the actual experience of self-assertion; to learn that one has freedom of choice, one must make choices. Thus, health care professionals who would have patients realize their personhood and their power to choose must not make decisions for them. Except where it is clear that the patient is incompetent and in need of protection, caregivers must ultimately insist that informed
patients make their own decisions and teach them how to make individual choices.

Health care professionals who insist that patients make their own decisions may be viewed as ultimately coercive, for they deny their patients the freedom to refuse choice. But whereas caregivers who accept a contractual definition of informed consent may insist that patients make their decisions alone, covenanting caregivers do not abandon patients to the terror of choosing wrongly.* Rather, they remain present as teachers to provide information, advice, and support as their patients make self-affirming decisions and live with their consequences.

The covenantal caregiver who teaches self-assertion must clearly acknowledge the difficulties inherent in self-determination, and understand the individual's need for others' compassionate presence as a source of strength. Covenentalism recognizes that human freedom, anxiety, and need for presence are inextricably connected. As best elaborated by Soren Kierkegaard, the individual's experience of freedom is a constant struggle with existential anxiety, anxiety produced by awareness that the freedom to choose carries with it the possibility of choosing wrongly [Kierkegaard, 1980a; 1980b]. Kierkegaard observed that many persons feel so threatened by the uncertainty of life that they elect to escape their anxiety by abandoning the struggle of self-assertion. The ability to live with
uncertainty, Kierkegaard argued, requires the knowledge and faith that God is present to the individual even in an uncertain world; God's presence can sustain the individual's will to be a self, and although anxiety remains, God's presence transforms it into a force for self-realization.

The image of God's presence which provides the model for covenantalism offers further support for caregivers' to require patients to make their own decisions. Kierkegaard insisted that God commands human beings to make choices but gives them the freedom to choose wrongly. While human freedom necessarily involves the burden of anxiety, it is the gift of freedom itself that gives human life its meaning. Although God has true compassion for human anxiety, fear, and pain, and suffers with persons who choose wrongly, God never imposes decisions upon others, for to remove the burden of choice would be to deny life's meaning. Instead, God offers compassionate presence as a source of wisdom on which to base decisions, strength that supports self-assertion, and affirmation that choice has meaning. The compassionate caregiver must similarly resist the urge to relieve patients' anxiety by making choices for them, and must provide the guidance, comfort, and reassurance that can support self-determination.

While theological conceptions of God's presence provide the essential model for covenantal caregivers' presence, other, secular arguments also support a role for human
presence in sustaining autonomy. Ironically, although a
sense of presence is all but missing from the common view of
contractual relationships, the conception of personhood upon
which contractualism is based recognizes that every
individual needs the active support of others in making
decisions. John Stewart Mill, whose secular vision of human
liberty is the central pillar of contractualism, maintained
that his dedication to human "liberty of action" was not
intended to promote indifference to others' behavior [Mill,
1859]. Despite his emphasis on personal privacy, Mill
believed that the threat of human fallibility made
discussion with others so essential to free choice that it
should be imposed on the individual who does not seek it.
Moreover, he argued that persons have an obligation to
assist others in achieving their true potential for freedom
by offering or even forcing them to heed advice and
admonitions designed to strengthen the will.

As Katz has noted, the lesson of psychiatry, a field
which owes much to Kierkegaard's analysis of personhood, is
that self-realization entails constant struggle with
personal freedom and its uncertainty, and that making
choices involves others in the struggle as well [Katz,
1984]. Katz emphasizes caregivers' duty to assist patients
in facing uncertainty prior to making decisions, as well as
during treatment and recovery; following Mill, Katz insists
that caregivers' obligation to respect their patients'
autonomy requires them to impose upon patients the conversation and reflection that will lead to free choice. In addition to enhancing patients' autonomy, Katz finds that caregivers' honest, compassionate presence engenders hope, faith, and reassurance whose placebo effect is as essential to modern health care as it was to ancient medicine.

Viktor E. Frankl, like Katz a proponent of existential psychiatry, has extended the concept of secular presence a step further. Frankl asserts that every doctor must learn to help patients live with the anxiety and despair of "existential frustration", an "illness" caused by an inability to find meaning in life when every possible choice leads to suffering [Frankl, 1955]. Frankl claims that "medical ministry" is the doctor's primary responsibility to patients with few options whose only certainty is pain. Rather than permitting suffering patients to abdicate their personhood, medical ministry teaches them that their self-assertion can coexist with fear of unknown, future suffering, and that their free self-realization gives meaning to life even where pain appears to deny it. Caregivers who affirm the dignity of suffering patients through medical ministry support their patients' capacities for choice and self-affirmation. They help patients to give meaning to unavoidable suffering by encouraging them to take responsibility for their responses to it.

The concept of encouragement -- fostering courage -- is
essential to covenantal presence. Shelp has suggested that the "will to accept responsibility" requires courage, and where patients fear uncertainty and the need to make choices, their caregivers' presence can give them the courage to take responsibility for choosing [Shelp, 1984]. True courage, for Shelp, is not the blind acceptance of risk, but the conscious, considered choice of a particular course of action despite the fact that it carries the threat of suffering. Caregivers can provide their patients with the encouragement that they need to act autonomously in the face of that threat by providing them with an honest evaluation of diagnosis, prognosis, and options, and compassionate discussion of the values, desires, and fears that affect their choices. Moreover, Shelp insists that caregivers must give patients the opportunity to be courageous; without the opportunity to demonstrate courage, patients may never realize one of the most creative and meaningful human responses to freedom.

Theologian Paul Tillich concluded that physicians, and particularly psychotherapists, have a special role in teaching courage because physicians' experience with health and illness gives them insight into human nature and anxiety [Tillich, 1952]. Tillich contended that self-affirmation demanded "the courage to be", courage which allows the individual to overcome the limitations imposed by anxiety. While Tillich criticized psychiatrists who sought to heal
all anxiety for denying the ontological and theological nature of existential anxiety, he praised the medical profession for its ability to teach self-affirmation in the face of uncertainty. Like Frankl, Tillich believed that the physician's job involved a certain ministerial function: doctors can implicitly encourage their patients to take existential anxiety upon themselves and balance the fear and courage inherent in self-affirmation.

As Tillich implied, doctors teach their patients to be courageous by being courageous themselves. Remaining present to patients requires the courage to face not only the uncertainty of human life, but, more importantly, the uncertainty of scientific medicine. Because patients often turn to physicians and other health care professionals with unrealistic and unreasonable expectations, it is vital for caregivers themselves to acknowledge the limitations of their science, and to accept the uncertainty that remains in even the best medicine [Herwig, 1986]. As Katz notes, doctors who fail to recognize their own fallibility and the limits of their science will be unable to share the burden of decision-making with their patients, for false certainty tempts them to assume control over their less confident patients [Katz, 1984].

Shelp has referred to the covenantal patient-caregiver relationship as an "alliance of uncertainty" in which both the strengths and the limitations of the healer's skills are
recognized, and the caregiver's presence to the patient is not diminished by an inability to cure [Shelp, 1984]. Where the illusion of certainty provokes health care professionals' condescending pity, courageous acceptance of uncertainty and tragedy creates a common bond of human suffering between caregivers and their patients, and promotes the compassion which makes presence possible. In this alliance moreover, patients' responses to uncertainty and suffering can also teach their caregivers tremendous lessons in courage and faith, returning the covenantal gift which transforms them both.

Health care professionals of all disciplines have a particularly important role to play in teaching patients to live courageously with uncertainty not only because their very occupations expose them far more than others to the often terrifying ambiguities of illness, and death, but also because they have professional skills which enable them to face uncertainty with strength and determination. Sociologist Renée Fox has demonstrated that students in the health professions learn quickly that they must make decisions, despite their uncertainty, in order to maintain their professional identity [Fox, 1957]. "Training for uncertainty" begins from the moment that the student begins clinical work; students are made keenly aware of how much they do not know and how much they can never know, yet they are repeatedly called to make choices. They rapidly learn
that the limits their own incomplete mastery of available knowledge are compounded by the existence of problems which even the best science cannot resolve. The struggle to know whether uncertainty is due to personal limitations or to those of the profession can create significant anxiety that must be overcome in order to provide treatment.

Health care professionals' ability to make therapeutic decisions is a professional skill in that caregivers must be able to judge the value of the information on which choices are made. But it is also a moral skill, because courageous decision-making requires a leap of faith. Caregivers must have faith in their ability to choose rightly and faith that in choosing wrongly they will neither destroy themselves, their patients, nor their profession's commitments. As Fox and her fellow sociologist Judith Swazey have argued, health care professionals have the courage to make choices because they have "the courage to fail" [Fox & Swazey, 1974].

Even beyond their response to the reality of uncertainty, however, the health care professions prove their moral skills in their response to tragedy. While many of the choices involved in health care offer the hope of complete recovery, often the choice is between tragic options; and despite scientific certainties, all too frequently even treatments which promise success result in tragedy due to human fallability and biological idiosyncracy [Hilfiker, 1984]. It is medicine's ability to face tragedy,
Hauerwas has argued, not its avowed dedication to others' wellbeing, that makes it a moral art [Hauerwas, 1977]. The courage which permits caregivers to continue working on others' behalf despite the pain of tragedy, and the presence that they offer to persons in tragic circumstances, provide a vital source of strength to patients who might otherwise seek to escape their suffering. Moreover, health care in general provides a rich source of practical understanding about the nature of tragedy in human existence.

Tragedy and the source of human presence in health care: sustaining the dedication to meaningful self-affirmation

Despite its extensive practical knowledge of the tragic, however, the modern conceptions of health care offer no comprehensive perspective on tragedy. Hauerwas has argued that, cut off from its theological roots by the demands of a pluralism, medicine no longer has a "story" capable of giving meaning to tragedy [Hauerwas, 1986]. Without such a "story", he claims, modern medicine will be unable to sustain the traditional dedication to presence, and will become entrapped in its search for scientific certainty and a solution to the "problem" of human life. Although he refrains from making medicine dependent upon theology, Hauerwas insists that in order to sustain its dedication to presence, medicine needs the church to provide an example of community faithfulness to those who suffer.

Hauerwas' assessment of the ability of secularized
medicine to sustain presence echoes Tillich's conclusions about secular existentialism's source of courage and self-affirmation. Tillich argued that the existentialist's claim that the self is ultimately only what it makes of itself limits the human possibilities for courage [Tillich, 1952]. Without faith in an absolute ground of being, the true courage to be is impossible, for the human freedom to be is finite. For Tillich, true courage requires the power to overcome the threat of uncertain fate, tragedy and death; while human powers cannot overcome these limitations on human freedom, the transcendent power of absolute being can. Like Kierkegaard, Tillich maintained that the courage behind self-affirmation requires a leap of faith, a faith which allows the finite person to experience the presence of absolute being. Thus, he insisted, because the only courage which can conquer the meaninglessness of tragedy and death is born of faith in God, physicians can serve only as helpers to the minister when they teach their patients courage and self-affirmation.

Tillich's documentation of the destructive power of "radical", secular existentialism provides a powerful critique of the purported liberating effects of a self-assertion that does not simultaneously affirm a source of meaning that transcends the self. Yet, the continued popularity of psychoanalysis and its methods attests to the ability of Frankl's medical ministry to teach patients how
their courageous self-affirmation endows suffering and tragedy with meaning. Moreover, Katz's dedication to presence, compassion, and conversation in every therapeutic relationship places him squarely in the covenantal model of health care, despite his secular approach. Inasmuch as medicine can never fully return to the province of theology, as even Hauerwas admits, the existential vision of the caregiver's compassionate presence sustaining patients' self-affirmation affords a valuable alternative to contractualism's indifference.

Nonetheless, the nature of a secular covenantal relationship and the source of its dedication to presence deserve continued scrutiny from theologians. As Hauerwas observes, physicians often embody unconscious beliefs and commitments which they may even consciously deny. Psychiatry's vigorous denial of the validity of religious beliefs and motivations have been likened by theologian Hans Kung to an obsession which, by the profession's own definitions, indicates that psychiatry clearly finds significant meaning in religion [Kung, 1988]. Kung's efforts at creating dialogue between theology and psychiatry should have valuable consequences for medical ethics.

Despite the lack of consensus on the source of sustaining presence and the ultimate meaning of suffering, illness remains a significant existential challenge for every human being. Because illness brings the vast majority
of Americans -- powerful and powerless, English-speaking and non -- into contact with health care professionals, the moral commitments of covenantal health care can be a significant liberating force in our society. Clearly, the ability of caregivers motivated by compassion to be a force for their patients' empowerment and self-realization is not absolute. There are the obvious limits which stem from the transient nature of many patients' interaction with the health care system and individual caregivers, as well as from the variations in patients' ailments and the subsequent decisions that they must make. In many situations covenantal informed consent may only plant the seeds of self-esteem and spark a belief in the possibility of choice. But although liberation and self-realization are not immediate phenomena, every opportunity for decision-making is valuable. Personhood has a growing edge, and self-assertion is not a single event but a lifelong challenge. Informed consent provides an opportunity for growth for all patients in all settings.

The transforming lessons of courage and self-realization which caregivers can teach their patients are independent of the specific technical skills of their individual disciplines. Every caregiver has an opportunity to teach patients to live courageously with existential anxiety and suffering, and to make the choices that shape life and affirm human dignity. Ultimately, the moral goal of any
therapeutic relationship is not simply the physical or psychological health of the patient, but the patient's ability to respond to illness and the uncertainty of life as a free and dignified person capable of making the choices that give life meaning. This interpretation of wellbeing unites the healing professions in a moral commitment that transcends their individual visions of professional duty. The caregiver's dedication to sustaining presence through the therapeutic covenant joins patients and compassionate professionals in a community of courageous fellow sufferers in which there are no strangers.

Notes to Chapter 6

1. This contention appears at first to conflict with his simultaneous insistence that the patient may refuse information. However, Engelhardt's argument is that either party may insist that certain of his or her wishes be respected, and may play the "trump" of ending the relationship when they are not. Thus, in the event that a physician insisted on disclosing certain information and the patient refused the disclosure, the doctor could rightfully refuse to treat the patient, who could also rightfully seek treatment elsewhere.

2. However, one of the central claims of the Latin American theology of liberation is that church leaders have advocated passive suffering for centuries as part of a campaign of oppression against the poor. Liberation theology recognizes suffering to have spiritual value, but promotes self-assertion as being both redemptive and more true to the Christian vision of the role of the poor [Gutierrez, 1968].

3. Cassell's textbook on talking with patients pays particular attention to the techniques essential to such dialogue.

4. This problem may occur easily in Spanish (and a number
of other European languages) in which there are both a formal and an informal "you", and corresponding verb conjugations. A Spanish-speaking patient would likely address his or her caregivers formally, but in some cases may expect to be referred to by the informal "you". While this may be hard for English-speaking persons to grasp, there is a significant difference in respect conveyed by the two forms.

The problem is not unique to non-English speaking persons, however. Educational, generational, racial, and economic factors which the caregiver may find unimportant to the patient's right to respect are often quite significant to the patient. If the caregiver's behavior is not consistent with the patient's self-image, the patient may react with embarrassment or shame, both of which can be destructive to their relationship (Lazare, 1987).

5. May insists that the "patient's rights" position on autonomy in decision-making espoused by Veatch in particular, results all too often in abandonment of the patient to his or her freedom to choose [May, 1987]. Katz similarly argues that physicians who provide their patients with scant information and little moral support are as guilty of abandonment as would be a doctor who physically deserts them.
Bibliography


Anonymous (1986b). City ranks seventh as Hispanic area: marketing study released. *Houston Post*, November 21, 6A.


Ben-Sira, Z. (1976). The function of the professional's


Engelhardt, H.T., Jr. (1982). Bioethics in pluralist societies. Perspectives in Biology and Medicine, 26, 64-78.


Franco, F., staff epidemiologist, Mexican Ministry of Health, personal communication, October 8, 1987.


Hickman, G.J., vice president, Texas Medical Center, Inc., Houston, TX. Personal communication, July 29, 1987.


Holm, C.B., defendants' malpractice attorney, Houston, TX. Personal communication, October 3, 1986 and January 5, 1987.


Miller, M. (1986). "I want my story told": an anthropological analysis of malpractice plaintiffs'
discourse. Unpublished Ph.D. dissertation, Rice University, Houston, TX.


access to health care. New York: Prodist, 130-44.


Texas Medical Center, Inc. (1983). *Annual report - 1982*. Houston, TX: Texas Medical Center, Inc.


Treviño, F.M., former director, American Medical Association Cross-Cultural Patient and Health Education Project, personal communication, September 10 and December 11, 1986.


van Eys, J. (1986). Presentation to the University of Texas School of Nursing - Houston on transcultural aspects of nursing, July 17.


Weller, C. (1972). Development of a master questionnaire inventory list and its use for physician customized history


Wright, M. (1981). This silence we could break. RN, 44 (December), 63.


APPENDICES
APPENDIX I
INFORMED CONSENT DOCUMENT

An Investigation into Communication between Hospital Patients and their Caregivers

PURPOSE OF STUDY
I understand that Elizabeth Heitman is conducting this investigation to study the communication between patients and hospital staff. I understand that this study involves a 30-minute interview with Elizabeth Heitman. She will ask me about my experiences in the hospital and my communication with hospital staff, and some questions will concern my medical history and personal background.

I also understand that Elizabeth Heitman will interview briefly up to five of the doctors, nurses, therapists, and others caring for me in order to compare their impressions with mine. I also recognize that she will review my medical chart for general information on my condition.

VOLUNTARY NATURE OF PARTICIPATION
I understand that my participation in this study is completely voluntary, and that if I decide not to participate there will be no effect whatsoever on my medical care. Similarly, I may withdraw from the study at any time, and may refuse to answer individual questions during the interview, without affecting my care in any way.

BENEFITS OF THE STUDY
I realize that this study itself provides no direct benefit to me. I understand, however, that during the study Elizabeth Heitman will be available to refer my questions and comments to appropriate staff members.

RISKS OF THE STUDY
I understand that the study has no known risks.

CONFIDENTIALITY
I understand that all information obtained during this investigation will be kept strictly confidential. Study results will be published in such a way that my anonymity will be maintained.

FURTHER INFORMATION
I understand that Elizabeth Heitman will answer any question concerning this study at any time. She can be contacted at (713) 792-5140 or (713) 432-7392.

PATIENT'S STATEMENT OF CONSENT
I have read the above statement, or it has been read to me, and I fully understand its contents. The purpose and nature of this study have been explained to me, I have no additional questions about it. I understand that I will receive a copy of this document.

My signature below means that I freely consent to participate in this study.

__________________________________________  ____________________________________________
Date                                           Patient's Signature

__________________________________________
Witness' Signature
DOCUMENTO DE CONSENTIMIENTO INFORMADO

Investigación sobre comunicaciones entre pacientes y personal hospitalario

PROPOSITO DEL ESTUDIO

Es de mi conocimiento que Elizabeth Heitman realiza esta investigación para estudiar las comunicaciones entre pacientes y el personal hospitalario. Entiendo que este estudio involucra una entrevista de 30 minutos con Elizabeth Heitman. Ella me formulará preguntas sobre mis experiencias en el hospital y mis comunicaciones con el personal hospitalario. Algunas preguntas se referirán a mi historia médica y mis antecedentes personales.

Entiendo que Elizabeth Heitman también entrevistará brevemente a hasta cinco de los varios médicos, enfermeras, terapeutas, y otros a cargo de mi cuidado, para comparar sus impresiones con las mías. Reconozco también que ella revisará mi record médico para obtener información general sobre mi condición.

NATURALEZA VOLUNTARIA DE LA PARTICIPACION

Entiendo que mi participación en este estudio es completamente voluntaria, y en el caso que yo decido no participar, me decisión no tendrá efecto alguno en el tratamiento que reciba. De la misma manera, puedo retirarme del estudio en cualquier momento y puedo rehusar responder a preguntas individuales durante la entrevista, sin que mi cuidado médico resulte afectado en ninguna manera.

BENEFICIOS DEL ESTUDIO

Reconozco que este estudio en sí mismo no me provee beneficio directo alguno. Entiendo, sin embargo, que durante este estudio Elizabeth Heitman estará dispuesta a referir mis preguntas y comentarios a los profesionales apropiados y traducir para mí.

RIESgos DEL ESTUDIO

Entiendo que el estudio no tiene ningún riesgo conocido.

CONFIDENCIALIDAD

Entiendo que toda la información obtenida durante este estudio será mantenida en confidencia absoluta. Los resultados serán publicados en forma tal que mi anonimato será preservado.

INFORMACION ADICIONAL

Entiendo que Elizabeth Heitman responderá a cualquier pregunta relacionada a este estudio, a cualquier hora. Puedo llamarla al (713) 792-5140 o (713) 432-7392.

DECLARACION DE CONSENTIMIENTO DEL PACIENTE

He leído este documento, o me lo han leído, y entiendo completamente el contenido. La naturaleza y propósito del estudio me han sido explicados y no tengo preguntas adicionales. Entiendo que recibiré una copia de este documento.

Mi firma al pie significa que consiento libremente en la participación en este estudio.

______________________________  ________________________________
Fecha  Firma del paciente

______________________________
Firma del testigo
APPENDIX II

Patient questionnaire

I would like to start with a few questions about your general medical condition.

Have you ever been a patient in a hospital before?
   a. Y   N
   b. When?
   c. Why were you hospitalized?

Have you ever been a patient in this hospital before?
   a. Y   N
   b. When?
   c. Why were you hospitalized?

What is wrong with you that you are in the hospital now?

How long have you had this condition?

What type of treatment did you seek before you came to the hospital?

What made you decide to come to the hospital?

How long have you been in the hospital?
Have you had tests or x-rays done?

Y   N

What were the tests or x-rays supposed to do?

What does your doctor say is wrong with you?

Why does your doctor think that it is ____________?

What treatment have you received?

What is this treatment supposed to do?

How well do you think that the treatment is working?

Very well - condition is much better............1
Fairly well - condition is somewhat better........2
Not at all - condition is the same/worse........3

How long do you expect to be in the hospital?
Many hospital personnel visit patients in their rooms. I am going to name several types of staff members, and I would like for you to tell me which ones have been in to see you since you arrived. Please say yes or no after each person.

a. Your primary doctor (Dr. ________) More than one?
b. A consulting specialist
c. A resident physician
d. A medical student
e. A nurse
f. A therapist (respiratory, physical, etc.)
g. A dietician
h. A social worker
i. A chaplain
j. A patient representative
k. A volunteer

Of all of the hospital personnel who have visited you, who have you felt the most comfortable talking to?

Who is the most difficult to talk to?

Who is the most helpful?

Who do you think understands the most about your condition?

Who do you think cares the most about your wellbeing?

Do you have family or friends who visit you or stay with you here in the hospital?

a. Y N

b. Who?

Most of the rest of my questions will be about your interaction with the staff that you say have visited you.
You said that there are ____ different doctors taking care of you. Although I know they often visit you together, I want to ask you some questions about them individually.

Do you know the name of your primary doctor? (Dr. ______)

Did you know him/her before you came to the hospital?

a. Y  N

b. How long have you known him/her?

c. How did you meet the him/her?

How often do you see your primary doctor in the hospital?

More than 5 times a day..........................1
Between 2 and 5 times a day......................2
Once a day.........................................3
Once every other day..............................4
Once since admission.........................5

How long does he/she usually spend with you on each visit?

More than 20 minutes.........................1
16 to 20 minutes.............................2
11 to 15 minutes............................3
6 to 10 minutes...............................4
3 to 5 minutes.................................5
1 to 2 minutes.................................6
Less than 1 minute..............................7

Does your primary doctor talk to you when he/she visits?

a. Y  N

b. If not, why do you think that he/she doesn't?
How well do you usually understand what he/she says or wants when he/she talks to you?

Very well - understand (almost) everything........1
Fairly well - understand some.......................2
Poorly - understand only a little...................3
Not at all - understand nothing.....................4

Do you ever talk to your primary doctor when he/she visits?

a. Y  N
b. If not, why not?

Do you feel that your primary doctor usually gives you an opportunity to ask questions/discuss your concerns? Do you

Have ample opportunity to discuss concerns........1
Have some opportunity to discuss concerns...........2
Have little opportunity to discuss concerns..........3
Have no opportunity to discuss concerns............4

How well does your primary doctor usually seem to understand your questions and comments?

Very well - understands (almost) everything.......1
Fairly well - understands some.....................2
Poorly - understands little.........................3
Not at all - understands nothing....................4

Are you satisfied with the way that your primary doctor usually answers your questions? Are you

Very satisfied.........................................1
Fairly satisfied.......................................2
Not very satisfied....................................3
Not at all satisfied..................................4
Aside from what you think of your primary doctor as a person, are you satisfied with the care that he/she gives? Are you

Very satisfied..................................................1
Fairly satisfied.................................................2
Not very satisfied.............................................3
Not at all satisfied...........................................4

Why do you say that?

Aside from how you feel that your primary doctor cares for your medical needs, do you like him/her as a person? Do you

Like him/her very much........................................1
Like him/her somewhat.......................................2
Do not like him/her much....................................3
Do not like him/her at all....................................4

Why do you say that?

Do you know how to reach your primary doctor?

a. Y   N

b. How?
You said that a ______ has also been in to see you. I want to ask you some questions about him/her/them. (If more than one, answer in terms of the ______ in general.)

Do you know the name(s) of (any of) your ______?

How often do you see the ______ here in the hospital?

More than 5 times a day.........................1
Between 2 and 5 times a day.....................2
Once a day........................................3
Once every other day...........................4
Once since admission............................5

How long does he/she/they usually spend with you on each visit?

More than 20 minutes.........................1
16 to 20 minutes...............................2
11 to 15 minutes..............................3
6 to 10 minutes...............................4
3 to 5 minutes.................................5
1 to 2 minutes.................................6
Less than 1 minute............................7

Does (any of) the ______ talk to you?

a. Y  N

b. If not, why do you think that he/she doesn't?
How well do you usually understand what the _______ says or wants when he/she/they talks to you?

Very well - understand (almost) everything.......1
Fairly well - understand some......................2
Poorly - understand a little.........................3
Not at all - understand nothing......................4

Do you talk to the _______

a. Y N
b. If not, why not?

Do you feel that the _______ usually gives you an opportunity to ask questions/discuss your concerns? Do you

Have ample opportunity to discuss concerns.......1
Have some opportunity to discuss concerns........2
Have little opportunity to discuss concerns.......3
Have no opportunity to discuss concerns..........4

How well does the _______ usually seem to understand your questions and comments?

Very well - understand (almost) everything.......1
Fairly well - understand some......................2
Poorly - understand a little.........................3
Not at all - understand nothing......................4

Are you satisfied with the way that the _______ usually answers your questions? Are you

Very satisfied.........................................1
Fairly satisfied........................................2
Not very satisfied......................................3
Not at all satisfied....................................4
Aside from what you think of the _______ as a person, are you satisfied with the care he/she/they gives you? Are you

Very satisfied........................................1
Fairly satisfied.......................................2
Not very satisfied.................................3
Not at all satisfied.................................4

Why do you say that?

Aside from how you feel that the _______ cares for your medical needs, do you like him/her/them as a person? Do you

Like him/her/them very much.....................1
Like him/her/them somewhat.....................2
Do not him/her/them like much...............3
Do not like him/her/them at all..............4

Why do you say that?

Do you know how to reach the _______?
  a. Y   N
  b. How?

We have been talking about the _______ as a group. Do all of the _______ fit this general description?
  a. Y   N
  b. If not, who is the best _______?
  c. Why do you say that?
  d. Who is the worst _______?
  e. Why do you say that?
Are you satisfied with the hospital's service in general? Are you

Very satisfied........................................1
Fairly satisfied.......................................2
Not very satisfied....................................3
Not at all satisfied....................................4

What do you like most about the hospital?

What do you like least about the hospital?

If you needed medical care in the future, would you want to come back here again? Would you

Definitely come back.................................1
Probably come back..................................2
Probably not come back..............................3
Definitely not come back............................4

Is there anything else that is important for me to know about your stay in the hospital that I haven't asked about?

There are just a few more questions about your background for statistical purposes and we will be finished with the interview.

Where do you live? In what city and state, or country?

What is your national citizenship?
Where were you born?

a. How long have you been in the U.S.?

b. Is this the first time that you have been in the U.S.?
   Y    N

c. How long have you been in the U.S. in total?

What is the last year of school that you have completed?

9th grade or before.................................1
10th or 11th grade..................................2
12th grade, H.S. diploma..........................3
1 year of college....................................4
2 or 3 years of college............................5
4 years of college, B.A./B.S. degree............6
Some post-graduate work...........................7
M.A./M.S. degree....................................8
Professional degree (Ph.D., J.D., M.D.)...........9

Are you currently working full-time, part-time, going to school, keeping house, or what?

a. Working full-time.................................1
   Working part-time................................2
   Temporarily laid off.............................3
   Unemployed........................................4
   Keeping house....................................5
   In school & working..............................6
   In school full-time................................7
   Retired............................................8
   Other.............................................9
b. What kind of work do you do?

Are you married, separated, divorced, widowed, or have you never been married?

Married..................................................1
Separated................................................2
Divorced..................................................3
Widowed..................................................4
Never married..........................................5

Do you have children?

a. Y  N

b. How many children do you have?

c. How many are in the Houston area now?

Approximately what was your annual household income last year (1984) before taxes; that is, what was the total income for all members of your household? I am going to read a list of categories and please stop me when I reach the category that includes your total household income for 1984.

Under $7,500.............................................1
$7,500 to $10,000.......................................2
$10,000 to $15,000.....................................3
$15,000 to $20,000.....................................4
$20,000 to $25,000.....................................5
$25,000 to $35,000.....................................6
$35,000 to $50,000.....................................7
$50,000 to $75,000.....................................8
Over $75,000............................................9
Quisiera empezar con unas pocas preguntas sobre su condición médica general.

Ha sido internado/a alguna vez en un hospital anteriormente?
   a. S    N
   b. Fuera de los EEUU?
   c. En los EEUU?
   d. Cuándo?
   e. Por qué lo/la hospitalizaron?

Ha sido internado/a en este hospital anteriormente?
   a. S    N
   b. Cuándo?
   c. Por qué lo/la hospitalizaron?

Cuál es el motivo por el cual está Ud. hospitalizado/a ahora?

Cuánto hace que Ud. tiene este problema?

Qué tipo de tratamiento buscó Ud. antes de venir al hospital?

Qué lo/la decidió venir al hospital?

Cuánto hace que está en el hospital?
Le han hecho exámenes o rayos x?
S   N

Para qué fueron los exámenes or rayos x?

Según el doctor, qué le pasa?

Por qué piensa el doctor que es ___________?

Qué tratamiento le han dado?

Para qué es este tratamiento?

En qué medida piensa Ud. que el tratamiento es efectivo?
Muy efectivo..................................................1
Más o menos efectivo......................................2
No efectivo en absoluto.................................3

Cuánto tiempo piensa Ud. estar en el hospital?

Entre el personal hospitalario hay muchos que visitan a pacientes en sus cuartos. Voy a nombrar varios tipos de miembros del personal, y me gustaría que Ud. me dijera cuáles lo/la han visitado desde su llegada. Por favor diga sí o no después de cada persona.
a. Su médico de cabecera (Dr. _______)  Más de una?
b. Una especialista que haya sido consultada
c. Un médico residente
d. Un estudiante de medicina
e. Una enfermera
f. Una terapeuta (respiratoria, física, etc.)
g. Una dietista
h. Una trabajadora social
i. Un capellán
j. Una representante de pacientes
k. Un voluntario/a
l. Un intérprete

De todo el personal hospitalario que lo/la ha visitado, con quién se ha sentido más cómodo/a hablando?

Quién le ha resultado más difícil para hablar?

Quién ha sido más servicial?

En su opinión, quién comprende mejor su problema?

En su opinión, a quién le interesa más su bienestar?

Tiene Ud. familia o amigos que lo/la visitan o se quedan aquí con Ud. en el hospital?

   a. S    N

b. Quién?

c. Quién de ellos habla inglés?

Casi todas las preguntas restantes serán sobre sus comunicaciones con el personal hospitalario que según Ud. lo/la han visitado.
Ud. dijo que hay _____ médicos diferentes que lo/la cuidan. Aunque sé que a menudo lo/la visitan juntos, quisiera hacerle algunas preguntas sobre cada uno individualmente.

Sabe Ud. el nombre de su médico de cabecera? (Dr. _____)

Conocía a su médico de cabecera antes de venir al hospital?
   a. S   N

   b. Cuánto hace que lo/la conoce?

   c. Cómo lo/la conoció?

Con qué frecuencia ve Ud. a él/ella aquí en el hospital?

   Más de 5 veces por día...............................1
   Entre 2 y 5 veces por día............................2
   Una vez por día.........................................3
   Día por medio..........................................4
   Una sola vez desde su internación....................5

Cuánto tiempo está él/ella generalmente con Ud. durante cada visita?

   Más de 20 minutos.....................................1
   De 16 a 20 minutos....................................2
   De 11 a 15 minutos...................................3
   De 6 a 10 minutos....................................4
   De 3 a 5 minutos......................................5
   De 1 a 2 minutos......................................6
   Menos de 1 minuto....................................7

Le habla su médico de cabecera cuando lo/la visita?
   a. S   N

   b. Si no, en su opinión, por qué no le habla?
Habla español su médico de cabecera? Diría Ud. que él/ella

Lo habla bien.................................1
Lo habla más o menos.........................2
Sabe solamente unas palabras....................3
No lo habla en absoluto.........................4

Generalmente, en qué medida comprende Ud. lo que él/ella dice o quiere cuando le habla

Muy bien - comprende (casi) todo....................1
Bastante bien - comprende algo..................2
Mal - comprende solo un poco....................3
En absoluto - no comprende nada..................4

Le habla Ud. a su médico de cabecera cuando lo/la visita?

a. S    N
b. Si no, por qué no?

Siente Ud. que él/ella generalmente le da la oportunidad de hacer preguntas y hablar sobre sus dudas? Tiene Ud.

Una amplia oportunidad de hablar sobre dudas........1
Una oportunidad de hablar sobre dudas...............2
Poca oportunidad de hablar sobre dudas.............3
Ninguna oportunidad de hablar sobre dudas...........4

Generalmente, en qué medida le parece a Ud. que él/ella comprende sus preguntas y comentarios?

Muy bien - comprende (casi) todo....................1
Bastante bien - comprende algo..................2
Mal - comprende solo un poco....................3
En absoluto - no comprende nada....................4
¿Está Ud. satisfecho/a con el modo en que él/ella contesta generalmente sus preguntas?  Está Ud.

Muy satisfecho/a......................................................1
Bastante satisfecho/a...............................................2
Poco satisfecho/a......................................................3
No satisfecho/a en absoluto.................................4

Hay muchas maneras en que se puede intentar comunicarse. Voy a enumerar algunas de ellas y me gustaría que Ud. me dijera cuáles ha utilizado para hablar con su médico de cabecera. Por favor diga sí o no después de cada una.

**Usted**

a. Oraciones en español únicamente
b. Palabras simples en español
c. Palabras simples en inglés
d. A través de un intérprete

Quién

e. Gestos y expresiones faciales
f. Ud. no habla
g. Otro

**Médico de cabecera**

h. Oraciones en español únicamente
i. Oraciones en inglés únicamente
j. Un poco de inglés, poco español
k. Palabras simples en español
l. Palabras simples en inglés
m. A través de un intérprete

Quién

n. Gestos y expresiones faciales
o. Habla únicamente con familia/visita

Quién

p. No lo/la habla
q. Otro

Cuál de estas formas utilizan Uds. más frecuentemente?
Además de lo que Ud. opina de su médico de cabecera como persona, está Ud. satisfecho/a con el cuidado que recibe Ud. de su parte? Está Ud.

Muy satisfecho/a........................................1
Bastante satisfecho/a....................................2
Poco satisfecho/a..........................................3
No satisfecho/a en absoluto..............................4

Por qué lo dice?

Además de cómo siente Ud. que su médico de cabecera trata su condición médica, le gusta a Ud. como persona? A Ud.

Le gusta mucho..............................................1
Le gusta algo..................................................2
No le gusta mucho.........................................3
No le gusta en absoluto.................................4

Por qué lo dice?

Sabe Ud. cómo ponerse en contacto con su médico de cabecera?

a. S N

b. Cómo?
Ud. dijo que un/a/s _______ también lo/la ha visitado. Quisiera preguntarle sobre él/ella/ellos. (En el caso de que hay más de uno, por favor responda pensando en todos en general.)

Sabe Ud. el nombre del _______?

Con qué frecuencia ve Ud. al ______ aquí en el hospital?

- Más de 5 veces por día.................................1
- Entre 2 y 5 veces por día..............................2
- Una vez por día...........................................3
- Día por medio.............................................4
- Una sola vez desde su internación.....................5

Cuánto tiempo está él/ella/ellos generalmente con Ud. durante cada visita?

- Más de 20 minutos........................................1
- De 16 a 20 minutos......................................2
- De 11 a 15 minutos.....................................3
- De 6 a 10 minutos......................................4
- De 3 a 5 minutos.......................................5
- De 1 a 2 minutos......................................6
- Menos de 1 minuto.....................................7

Le habla él/ella/ellos cuando lo/la visita?

a. S N

b. Si no, en su opinión, por qué no le habla?
Habla español él/ella/ello ______? Diría Ud. que Quién

Lo habla bien..............................................1
Lo habla más o menos.................................2
Sabe solamente unas palabras.....................3
No lo habla en absoluto..............................4

Generalmente, en qué medida comprende Ud. lo que él/ella/ello dice o quiere cuando le habla

Muy bien - comprende (casi) todo...................1
Bastante bien - comprende algo....................2
Mal - comprende solo un poco.....................3
En absoluto - no comprende nada..................4

Le habla Ud. al ______ cuando lo/la visita?

a. S    N

b. Si no, por qué no?

Siente Ud. que él/ella/ello generalmente le da la oportunidad de hacer preguntas y hablar sobre sus dudas? Tiene Ud.

Una amplia oportunidad de hablar sobre dudas.....1
Una oportunidad de hablar sobre dudas.............2
Poca oportunidad de hablar sobre dudas...........3
Ninguna oportunidad de hablar sobre dudas.......4

Generalmente, en qué medida le parece a Ud. que él/ella/ello comprende sus preguntas y comentarios?

Muy bien - comprende (casi) todo....................1
Bastante bien - comprende algo....................2
Mal - comprende solo un poco.....................3
En absoluto - no comprende nada..................4
Está Ud. satisfecho/a con el modo en que el ______ contesta generalmente sus preguntas? Está Ud.

Muy satisfecho/a.............................................1
Bastante satisfecho/a.................................2
Poco satisfecho/a..........................................3
No satisfecho/a en absoluto..........................4

Hay muchas maneras en que se puede intentar comunicarse. Voy a enumerar algunas de ellas y me gustaría que Ud. me dijera cuáles ha utilizado para hablar con el ______. Por favor diga si o no después de cada una.

Usted
   a. Oraciones en español únicamente
   b. Palabras simples en español
   c. Palabras simples en inglés
   d. A través de un intérprete

Quién

   e. Gestos y expresiones faciales
   f. Ud. no habla
   g. Otro

   h. Oraciones en español únicamente
   i. Oraciones en inglés únicamente
   j. Un poco de inglés, poco español
   k. Palabras simples en español
   l. Palabras simples en inglés
   m. A través de un intérprete

Quién

   n. Gestos y expresiones faciales
   o. Habla únicamente con familia/visita

Quién

   p. No lo/la habla
   q. Otro

Cuál de estas formas utilizan Uds. más frecuentemente?
Además de lo que Ud. opina del _______ como persona, está Ud. satisfecho/a con el cuidado que recibe Ud. de su parte? Está Ud.

Muy satisfecho/a..................................................1
Bastante satisfecho/a.............................................2
Poco satisfecho/a..................................................3
No satisfecho/a en absoluto.................................4

Por qué lo dice?

Además de como siente Ud. que él/ella/ellos trata su condición médica, le gusta a Ud. como persona? A Ud.

Le gusta mucho......................................................1
Le gusta algo........................................................2
No le gusta mucho................................................3
No le gusta en absoluto.........................................4

Por qué lo dice?

Sabe Ud. cómo ponerse en contacto con el ______?

a. S N

b. Cómo?

Hemos estado hablando sobre todos los ______ a nivel de grupo. Corresponden todos a esta descripción general?

a. S N

b. Si no, cuál es el mejor ______?

c. Por qué dice eso?

d. Cuál es el peor ______?

e. Por qué dice eso?
Sabe Ud. el nombre del intérprete que lo/la visitó?

Con qué frecuencia ve Ud. al intérprete aquí en el hospital?

- Más de 5 veces por día..........................1
- Entre 2 y 5 veces por día........................2
- Una vez por día......................................3
- Día por medio.......................................4
- Una sola vez desde su internación..............5

Cuánto tiempo esta él/ella generalmente con Ud. durante cada visita?

- Más de 20 minutos.................................1
- De 15 a 20 minutos..............................2
- De 11 a 15 minutos..............................3
- De 6 a 10 minutos...............................4
- De 3 a 5 minutos.................................5
- De 1 a 2 minutos.................................6
- Menos de 1 minuto...............................7

Para quién ha traducido el intérprete?

Sobre qué asunto quería el _______ hablar con Ud. a través del intérprete?

Alguna vez ha llamado Ud. mismo a un intérprete?

- a. S  N
- b. Para qué?
Generalmente, en qué medida comprende Ud. lo que dice el intérprete cuando le habla?

Muy bien - comprende (casi) todo.................1
Bastante bien - comprende algo.....................2
Mal - comprende solo un poco.......................3
En absoluto - no comprende nada....................4

Siente Ud. que el intérprete generalmente le dan la oportunidad de hacer preguntas y hablar sobre sus dudas? Tiene Ud.

Una amplia oportunidad de hablar sobre dudas.....1
Una oportunidad de hablar sobre dudas...............2
Poca oportunidad de hablar sobre dudas..............3
Ninguna oportunidad de hablar sobre dudas..........4

Generalmente, en qué medida le parece a Ud. que el intérprete comprende sus preguntas y comentarios?

Muy bien - comprende (casi) todo...................1
Bastante bien - comprende algo....................2
Mal - comprende solo un poco......................3
En absoluto - no comprende nada....................4

Además de lo que Ud. opina del intérprete como persona, está Ud. satisfecho/a con el servicio que recibe Ud. de su parte? Esta Ud.

Muy satisfecho/a......................................1
Bastante satisfecho/a.................................2
Poco satisfecho/a....................................3
No satisfecho/a en absoluto..........................4

Por qué lo dice?
Además de cómo siente Ud. que el intérprete trata su condición médica, le gusta a Ud. como persona? A Ud.

Le gusta mucho...............................................1
Le gusta algo................................................2
No le gusta mucho...........................................3
No le gusta en absoluto....................................4

Por qué lo dice?

Sabe Ud. cómo ponerse en contacto con el intérprete?

a. S  N

b. Cómo?

Hemos estado hablando sobre todos los intérpretes a nivel de grupo. Corresponden todos a esta descripción general?

a. S  N

b. Si no, cuál es el mejor intérprete?

c. Por qué dice eso?

d. Cuál es el peor intérprete?

e. Por qué dice eso?
Está Ud. satisfecho/a con los servicios del hospital en general? Está Ud.

Muy satisfecho/a........................................1
Bastante satisfecho/a.................................2
Poco satisfecho/a........................................3
No satisfecho/a en absoluto.........................4

Qué es lo que más le gusta del hospital?

Qué es lo que menos le gusta del hospital?

Si necesitará Ud. cuidados médicos en el futuro, querría Ud. volver aquí? Diría Ud. que

Sin duda volvería........................................1
Probablemente volvería..............................2
Probablemente no volvería..........................3
Sin duda no volvería....................................4

Hay alguna otra cosa que no le haya preguntada y que Ud. considera que me ayudara a comprender lo que significa estar en el hospital y no saber hablar en inglés?

Hay unas pocas preguntas restantes sobre sus antecedentes personales para uso estadístico y habremos terminado la entrevista.

Dónde vive Ud.? En qué ciudad y estado, o país?

De qué país o países es Ud. ciudadano/a?
Dónde nació Ud.?

a. Cuánto hace que está Ud. en los EEUU?

b. Es la primera vez que Ud. está en los EEUU?
   S   N

c. Cuánto tiempo ha pasado Ud. en los EEUU en total?

Cuál fue el último año de escuela, colegio, or universidad que Ud. terminó?

9° grado o menos.................................1
10° o 11° grado.................................2
12° grado o diploma del colegio...............3
1 año de la universidad......................4
2 o 3 años de la universidad................5
4 años de la universidad o diploma universitario.6
Algunos cursos de post-grado................7
Una maestría........................................8
Un doctorado......................................9

Trabaja Ud. 40 horas a la semana, menos de la 40, asiste a la escuela, se dedica a la casa, o qué hace?

a. Trabaja 40 horas..............................1
   Trabaja menos de las 40 horas...............2
   Está temporariamente despedido/a...........3
   Está desocupado/a............................4
   Se dedica a la casa...........................5
   Asiste a la escuela & trabaja...............6
   Asiste a la escuela...........................7
   Está jubilado/a...............................8
   Otro...........................................9
b. A qué se dedica Ud.?

Está Ud. casado/a, separado/a, divorciado/a, viudo/a, o soltero/a?

Casado/a.................................................1
Separado/a...............................................2
Divorciado/a............................................3
Viudo/a....................................................4
Soltero/a..................................................5

Tiene Ud. hijos?

a. S   N

b. Cuántos hijos tiene?

c. Cuántos están en Houston o sus alrededores ahora?

Aproximadamente, cuál fue el ingreso total de su familia durante el año pasado (1984) antes de pagar impuestos; o sea, los ingresos de todos los miembros de su familia que viven con Ud. Voy a leer una lista de categorías, y por favor déjame cuándo llegue a la categoría que incluye su ingreso total del año pasado.

Menos de $7,500........................................1
$7,500 hasta $10,000.................................2
$10,000 hasta $15,000..............................3
$15,000 hasta $20,000..............................4
$20,000 hasta $25,000..............................5
$25,000 hasta $35,000..............................6
$35,000 hasta $50,000..............................7
$50,000 hasta $75,000..............................8
Mas de $75,000...........................................9
APPENDIX III

Staff questionnaire

Code #_____________ Position_____________

How long have you been taking care of this patient?

What was your patient's chief complaint upon admission?

What is his/her primary diagnosis?

How long is he/she expected to be in the hospital?

How often do you see this patient?

more than 5 times a day.................................1
between 2 to 5 times a day..............................2
once a day..................................................3
once every other day....................................4
once since admission....................................5

How long do you usually spend with him/her on each visit?

more than 20 minutes.................................1
16 to 20 minutes......................................2
11 to 15 minutes......................................3
6 to 10 minutes........................................4
3 to 5 minutes..........................................5
1 to 2 minutes.........................................6
less than 1 minute....................................7
How well do you usually understand what your patient says or wants?

Very well - understand (almost) everything......1
Fairly well - understand some.......................2
Poorly - understand a little.........................3
Not at all - understand nothing....................4

How well does the patient usually seem to understand your questions and comments?

Very well - understands (almost) everything......1
Fairly well - understands some.....................2
Poorly - understands a little.......................3
Not at all - understands nothing...................4

Do you feel that he/she usually has an adequate opportunity to ask questions and discuss concerns with you? Would you say that he/she has

Ample opportunity for discussion.....................1
Some opportunity for discussion.....................2
Little opportunity for discussion....................3
No opportunity for discussion.......................4

Is there anything about this patient that is particularly different from other patients that you have cared for in the past?

a. Y  N

b. If yes, what?
Do you speak Spanish?

Speak fluently

Speak somewhat

Know only a few words

Speak no Spanish

I am going to list some of ways that can be used to communicate with NESPs and I would like you to tell me which of them you and your NESP(s) have used. Please say yes or no after each one.

Patient

a. Sentences in Spanish only
b. Simple Spanish words
c. Simple English words
d. Through interpreter

Who

e. Gesture & facial expression
f. Doesn't talk
g. Other

You

h. Sentences in Spanish only
i. Sentences in English only
j. Some English, some Spanish
k. Simple Spanish words
l. Simple English words
m. Through interpreter

Who

n. Gesture & facial expression
o. Speak only to family member/visitor

Who

p. Don't talk
q. Other

Which of these ways do you and your NESP(s) use most frequently?
APPENDIX IV

Patient responses to survey on allied health and social service personnel

Therapists and dieticians

Table 1. "Does the therapist/dietician talk to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=3</th>
<th>ESPS N=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3 (100%)</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 2. "How does the therapist/dietician usually try to communicate with you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in Spanish</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Simple words in Spanish</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Simple words in English</td>
<td>1 (33%)</td>
</tr>
</tbody>
</table>

Table 3. "How well do you usually understand what the therapist/dietician says or wants when he/she talks to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=3</th>
<th>ESPS N=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>1 (33%)</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>2 (67%)</td>
<td>--</td>
</tr>
<tr>
<td>Poorly</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
Table 4. "Do you talk to the therapist/dietician?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs</th>
<th></th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3 (100%)</td>
<td>5 (100%)</td>
<td></td>
</tr>
<tr>
<td>[Little</td>
<td>1 (33%)</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

Table 4a. "Why don't you talk to him/her?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little</td>
<td></td>
</tr>
<tr>
<td>Just to answer questions</td>
<td>2 (40%)</td>
</tr>
</tbody>
</table>

Table 5. "How do you usually try to communicate with the therapist/dietician?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in Spanish</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Simple words in Spanish</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Simple words in English</td>
<td>2 (67%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.
Table 6. "Do you feel that the therapist/dietician usually gives you an opportunity to ask questions and discuss your concerns?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=3</th>
<th>ESPs N=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ample opportunity</td>
<td>2 (67%)</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>Some opportunity</td>
<td>1 (33%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Little opportunity</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>No opportunity</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 7. "Are you satisfied with the way that the therapist/dietician usually answers your questions?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=3</th>
<th>ESPs N=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>2 (67%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>1 (33%)</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>

Table 8. "Aside from what you think of the therapist/dietician as a person, are you satisfied with the care that he/she gives you?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=3</th>
<th>ESPs N=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>1 (33%)</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>2 (67%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
Table 9. "Why do you say that (you are satisfied)?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=3</th>
<th>ESPs N=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>They treat me well/</td>
<td>1 (33%)</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>are attentive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spent time explaining</td>
<td>1 (33%)</td>
<td>--</td>
</tr>
<tr>
<td>Spoke Spanish</td>
<td>--</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (33%)</td>
<td>2 (40%)</td>
</tr>
</tbody>
</table>

Social workers and chaplains

Table 10. "Does the social worker/chaplain talk to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=2</th>
<th>ESPs N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2 (100%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 11. "How does the social worker/chaplain usually try to communicate with you?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in Spanish</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Through an interpreter</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Hospital interpreter/staff</td>
<td>1 (50%)</td>
</tr>
</tbody>
</table>
Table 12. "How well do you usually understand what the social worker/chaplain says or wants when he/she talks to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=2</th>
<th>ESPs N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>2 (100%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Poorly</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 13. "Do you talk to the social worker/chaplain?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=2</th>
<th>ESPs N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2 (100%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 14. "How do you usually try to communicate with the social worker/chaplain?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentences in Spanish</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Through an interpreter</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Hospital interpreter/staff</td>
<td>1 (50%)</td>
</tr>
</tbody>
</table>
Table 15. "Do you feel that the social worker/chaplain usually gives you an opportunity to ask questions and discuss your concerns?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=2</th>
<th>ESPs N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ample opportunity</td>
<td>1 (50%)</td>
<td>5 (83%)</td>
</tr>
<tr>
<td>Some opportunity</td>
<td>--</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Little opportunity</td>
<td>1 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>No opportunity</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 16. "Are you satisfied with the way that the social worker/chaplain usually answers your questions?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=2</th>
<th>ESPs N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>1 (50%)</td>
<td>5 (83%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>1 (50%)</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 17. "Aside from what you think of the social worker/chaplain as a person, are you satisfied with the care that he/she gives you?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=3</th>
<th>ESPs N=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>--</td>
<td>5 (83%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>2 (100%)</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
Table 18. "Why do you say that (you are satisfied)?"  

<table>
<thead>
<tr>
<th>Reason</th>
<th>NESPs N=2</th>
<th>ESPs N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>They treat me well/</td>
<td>1 (50%)</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>are attentive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Told me to call anytime</td>
<td>--</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>Spent time explaining/</td>
<td>--</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>talking with me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spoke Spanish</td>
<td>--</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (50%)</td>
<td>2 (40%)</td>
</tr>
</tbody>
</table>

Percentages total over 100% due to multiple responses.

Patient representatives, interpreters, and volunteers

Table 19. "Does the patient representative/interpreter talk to you?"

<table>
<thead>
<tr>
<th></th>
<th>NESPs N=12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12 (100%)</td>
</tr>
<tr>
<td>No</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 20. "How well do you usually understand what the patient representative/interpreter says or wants when she talks to you?"

<table>
<thead>
<tr>
<th>Understanding</th>
<th>NESPs N=12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>12 (100%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>--</td>
</tr>
<tr>
<td>Poorly</td>
<td>--</td>
</tr>
<tr>
<td>Not at all</td>
<td>--</td>
</tr>
</tbody>
</table>
### Table 21. "For whom did the patient representative/interpreter translate?"

<table>
<thead>
<tr>
<th>Role</th>
<th>NESP (N=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>7 (59%)</td>
</tr>
<tr>
<td>Nurse</td>
<td>5 (42%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>N/A -- just visiting</td>
<td>5 (42%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

### Table 22. "What did that person want to talk to you about?"

<table>
<thead>
<tr>
<th>Topic</th>
<th>Visits (N=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teach self/baby care</td>
<td>6 (38%)</td>
</tr>
<tr>
<td>Consent forms</td>
<td>3 (19%)</td>
</tr>
<tr>
<td>Complete other forms</td>
<td>3 (19%)</td>
</tr>
<tr>
<td>Explain outcome of surgery</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (13%)</td>
</tr>
</tbody>
</table>

Percentages total more than 100% due to multiple responses.

### Table 23. "Do you talk to the patient representative/interpreter?"

<table>
<thead>
<tr>
<th>Response</th>
<th>NESP (N=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12 (100%)</td>
</tr>
<tr>
<td>No</td>
<td>--</td>
</tr>
</tbody>
</table>
Table 24. "Do you feel that the patient representative/interpreter usually gives you an opportunity to ask questions and discuss your concerns?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ample opportunity</td>
<td>10 (83%)</td>
</tr>
<tr>
<td>Some opportunity</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>Little opportunity</td>
<td>--</td>
</tr>
<tr>
<td>No opportunity</td>
<td>1 (8%)</td>
</tr>
</tbody>
</table>

Table 25. "Are you satisfied with the way that the patient representative/interpreter usually answers your questions?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>10 (83%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>--</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
</tr>
<tr>
<td>N/A - asked no questions</td>
<td>1 (8%)</td>
</tr>
</tbody>
</table>

Table 26. "Aside from what you think of the patient representative/interpreter as a person, are you satisfied with the care that she gives you?"

<table>
<thead>
<tr>
<th></th>
<th>NESP N=12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>10 (83%)</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>Not very satisfied</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>Not at all satisfied</td>
<td>--</td>
</tr>
</tbody>
</table>
Table 27. "Why do you say that (you are satisfied)?"

<table>
<thead>
<tr>
<th>Reason</th>
<th>NESPs N=11</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Answered questions/ explains well</td>
<td>3 (27%)</td>
<td></td>
</tr>
<tr>
<td>Friendly/ good person</td>
<td>3 (27%)</td>
<td></td>
</tr>
<tr>
<td>Couldn't have understood without them</td>
<td>2 (18%)</td>
<td></td>
</tr>
<tr>
<td>They treat me well/</td>
<td>2 (18%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1 ( 9%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 27a. "Why do you say that (you are not satisfied)?"

<table>
<thead>
<tr>
<th>Reason</th>
<th>NESPs N=1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Left too fast -- I didn't get to talk to her</td>
<td>1 (100%)</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX V

Correlation of the perceptions of allied health and social service personnel and their patients

Table 1. How often does the staff member visit the patient?

<table>
<thead>
<tr>
<th></th>
<th>Correlation</th>
<th>NESP</th>
<th>ESPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dieticians/Therapists</td>
<td>+1</td>
<td>1 (100%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td></td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Social Workers/Chaplains</td>
<td>0</td>
<td>2 (100%)</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>+2</td>
<td>2 (40%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>+1</td>
<td></td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>3 (60%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 2. How much time does the staff member spend with the patient during an average visit?

<table>
<thead>
<tr>
<th></th>
<th>Correlation</th>
<th>NESP</th>
<th>ESPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dieticians/Therapists</td>
<td>+1</td>
<td>--</td>
<td>1 (33%)</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>--</td>
<td>2 (67%)</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-3</td>
<td>1 (100%)</td>
<td>--</td>
</tr>
<tr>
<td>Social Workers/Chaplains</td>
<td>0</td>
<td>2 (100%)</td>
<td>2 (67%)</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>--</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>+3</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>+2</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>+1</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>1 (20%)</td>
<td>--</td>
</tr>
</tbody>
</table>
Table 3. How well does the staff member speak Spanish?

<table>
<thead>
<tr>
<th></th>
<th>Correlation</th>
<th>NESP (%)</th>
<th>ESP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dieticians/Therapists</td>
<td>+1</td>
<td>1 (100%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Social Workers/Chaplains</td>
<td>+1</td>
<td>1 (50%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-2</td>
<td>1 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>0</td>
<td>5 (100%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 4. How well does the staff member understand the patient?

<table>
<thead>
<tr>
<th></th>
<th>Correlation</th>
<th>NESP (%)</th>
<th>ESP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dieticians/Therapists</td>
<td>+1</td>
<td>1 (33%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>--</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Social Workers/Chaplains</td>
<td>0</td>
<td>1 (50%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>--</td>
<td>3 (100%)</td>
</tr>
<tr>
<td></td>
<td>-2</td>
<td>1 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>0</td>
<td>5 (100%)</td>
<td>--</td>
</tr>
</tbody>
</table>
Table 5. How well does the patient understand the staff member?

<table>
<thead>
<tr>
<th></th>
<th>Correlation</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dieticians/Therapists</td>
<td>+1</td>
<td>1 (33%)</td>
<td>--</td>
</tr>
<tr>
<td>Social Workers/Chaplains</td>
<td>0</td>
<td>1 (50%)*</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>--</td>
<td>3 (100%)</td>
</tr>
<tr>
<td></td>
<td>-2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-3</td>
<td>1 (50%)</td>
<td>--</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>0</td>
<td>5 (100%)</td>
<td>--</td>
</tr>
</tbody>
</table>

Table 6. How much opportunity does the patient have for discussion with the staff member?

<table>
<thead>
<tr>
<th></th>
<th>Correlation</th>
<th>NESPs</th>
<th>ESPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dieticians/Therapists</td>
<td>0</td>
<td>1 (100%)</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Social Workers/Chaplains</td>
<td>0</td>
<td>1 (50%)*</td>
<td>2 (67%)</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>1 (50%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>-2</td>
<td>--</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Patient Reps/Interpreters</td>
<td>0</td>
<td>5 (100%)</td>
<td>--</td>
</tr>
</tbody>
</table>

* via an official interpreter