Language as a Barrier to Patient Education:

A View from Behind the Desk

By

Patricia Dunn
BSc., Our Lady of the Elms College, 1986

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENT FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

In

THE FACULTY OF
GRADUATE STUDIES
The School of Nursing

We accept this thesis as conforming
to the required standards

THE UNIVERSITY OF BRITISH COLUMBIA
May 2002
© Patricia Dunn, 2002
In presenting this thesis in partial fulfilment of the requirements for an advanced
degree at the University of British Columbia, I agree that the Library shall make it
freely available for reference and study. I further agree that permission for extensive
copying of this thesis for scholarly purposes may be granted by the head of my
department or by his or her representatives. It is understood that copying or
publication of this thesis for financial gain shall not be allowed without my written
permission.

Department of Nursing

The University of British Columbia
Vancouver, Canada

Date April 26, 2002
Abstract

Three factors provide the background for this research study, the efficacy of patient education in influencing health outcomes, the significant growth of immigration and the change in predominant countries of origin for immigrants and the Canadian ideal of equity and quality in health care. Together these factors combine to create a dilemma, of how does a predominantly ‘white’, ‘western’, and European, nursing tradition meet the educational needs of non-English speaking patients particularly those from a culture with origins different from those of the majority.

Although there is a relatively recent accumulation of health literature about the difficulties encountered by non-English speaking patients when attempting to access health care, there appears to be a profound lack of research and information relating to teaching non-English speaking patients. Using interpretive description, a qualitative research method designed by nurses, this study explored the experiences and perceptions of seven nurse educators about the barriers that language can create in the process of health education.

The findings presented an inventory of concerns germane to the participants, from not being aware of specific cultural health beliefs to lack of support for professional interpreters and an inability to effectively assess comprehension of a non-English speaking patient. Participants spoke of difficulty in ascertaining if the answer to a question was the response of the patient or of the friend doing the interpretation. The educators were concerned that patients might not disclose important sensitive matters when a family member or family member was the only means of communication. Feelings of inadequacy were reported when cultural differences, of which the participants
had no prior knowledge, were a source of misunderstandings. Another major factor that affected the participants was the perceived lack of administrative support for and knowledge about patient education of non-English speaking patients.

In the analysis of the findings, it became evident that these factors that affected not only the encounter between the educator and the patient but also affected the educator directly and contributed to an overall negative perception of teaching non-English speaking patients. This perception, which was generated by the factors affecting the educators, in turn produced unintended outcomes of the patient-educator encounter including possible decrease in patient self care and ongoing health status as well as educator frustration, sense of inadequacy and self-directed blame. The result of these outcomes produced an ongoing struggle for the educators to find avenues for increasing their knowledge of diverse cultures and health beliefs and to improve their understanding of the basic principles of adult learning.

This study has highlighted several aspects of the current practice of education for non-English speaking patients, which have nursing implications for practice, education, research, and administration.
# Table of Contents

Abstract ii  
Table of Contents iv  
List of Figures viii  
Acknowledgements ix  

Chapter One: Introduction 1  
   Background to the Problem 1  
   Statement of the Problem 7  
   Purpose 8  
   Research Questions 8  
   Definition of Terms 8  
   Significance 9  
   Organization of Thesis 10  

Chapter Two: Literature Review 11  
   Literature Review 11  
      Process 11  
      Language and Patient Education 13  
      Language and Access to Health Care 17  
      Summary of Literature Review 27  
   Forestructure 28  
      Personal Experience 28  
      Assumptions 29  
      Analytic Framework 30
Chapter Three: Research Method

Research Design

Participant Selection

Rationale

Inclusion criteria

Process for Selection of Participants

Data Collection

Data Analysis

Rigor

Ethical Considerations

Limitations of the Study

Summary

Chapter Four: Findings

Factors Affecting the Experience of the Educators

Nature of Content

Knowledge about Teaching

Knowledge about Other Cultures

Resources

Literature

Continuing Education

Time

Personnel
List of Figures

Figure # 1  33
Figure # 2  86
Acknowledgements

This thesis would not have been possible without the help and encouragement of many people.

It is with much emotion and deep gratitude that I acknowledge all those who brought me to this day in my life. There were many whose assistance and support were crucial to my completion of this endeavor. Firstly and without equivocation I wish to acknowledge my committee members, Barbara Paterson, France Boulibette, and Sally Thorne for their perseverance, patience, and unflinching encouragement regardless of my physical or emotional state of being. To Barbara, I am forever indebted to you for your ability to create a safe, accepting, and enthusiastic place to grow. Your belief in my ability sustained me at times that would otherwise have devoured me and your help provided a strong foundation for this undertaking. France, you helped me to find a path when I was quite lost early in my quest, you endured my questions, indecisions, and literary meanderings, with grace and serenity. And Sally, you are the quintessential guide, you looked out for me but didn’t minimize the challenge, you were sincere in your belief in me and enthusiastic in your support, but you still held me to a very high standard. I am grateful for your expectations, thoughtful assistance and respect.

I am, of course, incredibly thankful for the wonderful and generous contributions of the hardworking and candid educators that participated in this research study. Your willingness to give of yourselves and share your experiences was the backbone of this thesis and provided the foundation for this final product. I hope that I faithfully represented your experiences and thoughts herein and that you as proud as I, of the contribution that you have made.

I would like to acknowledge my friends and many colleagues who have not only wished me well and encouraged me but conspired to provide support in the most ingenious of ways. Kathy, you have been a rock, immoveable in your faith in my capacity to succeed. From my friends in the early days of study groups to those who have struggled alongside me this past year or more, and my family (though distant you may be) you are all a part of this thesis. Your prayers, unwavering encouragement, and unshakable belief leveled the nearly overwhelming task to a difficult but manageable climb. I thank you with all my heart.

I would also like to gratefully acknowledge the financial assistance given to me by the Kidney Foundation of Canada and the Canadian Association of Nephrology Nurses and Technologists. These benefactors helped to make this research possibility a reality.
Chapter One: Introduction

As a Nephrology educator for the last few years I was afforded the opportunity to provide Predialysis education to patients with renal insufficiency and their families. In this capacity, I experienced an ever-increasing number of ethnically diverse patients and their families. Within this time, I worked with many individuals who as a whole spoke 17 different languages; I became frustrated with the limited strategies for educating and assisting learning of patients with limited English proficiency. Not only were resources limited, but there was scant information available about how to deal with the formidable barriers presented when patients were unable to speak English or had limited understanding of English. It is important to identify the most appropriate and efficient methods to address the issue of limited English language comprehension in patient education. This research describes and explores the experience of nurses providing education to patients who do not speak English or have limited English proficiency in order to determine if the practice issue I encountered is mirrored in the practice of other educators.

Background to the Problem

There are three factors that provide a background and lend impetus to this study. The first is that of patient teaching as integral to maintaining and/or improving health. The second factor is the increasing number of non-English speaking patients who are accessing health care today. Together these two factors create a paradox. On the one hand, health care practitioners assert that patient education is an integral component in health care, while on the other hand, there is a burgeoning sector of our population that are unable to fully participate or engage our services because of the inability to fully
comprehend the English language. The final and perhaps most crucial underlying factor is the Canadian ideal of equity and quality in health care (Rachlis & Kushner, 1992). This last factor is critical because not only does it help define the issue, but also, it informs our practice as nurses in Canadian society.

These three factors, patient education, target population, and ideal practice come together in such a way as to present a challenge to educators. In fact, they present a practice dilemma. Although there is a client group that needs help and assistance, and practitioners have an ethical responsibility to provide equitable high-quality care, these practitioners are faced with a significant barrier, language, which they are ill equipped to surmount.

It is not difficult to show the importance of patient teaching within nursing. Today, patient education is accepted not only as a fundamental aspect of nursing responsibility (Redman, 1997), but as a necessity for optimum patient care and involvement in decision-making (Taylor, Lillis, et al., 1997). A prominent nursing diagnosis from the North American Nursing Diagnosis Association (NANDA, North American Nursing Diagnosis Association, 1994) is "Knowledge Deficit". The existence of such a diagnosis indicates that every nurse must be able to assess data, plan, execute, and evaluate actions to ameliorate or eliminate a knowledge deficit (Springhouse Corporation, 1987). To do this, the nurse must not just provide information, but assess the patient's need and readiness, plan and implement an intervention, as well as evaluate the outcome. The nurse will finally determine if the deficit has been resolved or to what degree the diagnosis remains. Basic nursing texts are filled with rationale for the teaching process and helpful hints to assist the novice in the critical skill of educating
patients (Craven & Hirnle, 1996; Taylor, Lillis, et al., 1997). Advanced nursing texts provide detailed chapters that contain in-depth patient teaching units. Almost every published nursing care plan has a patient education component of care (Johns Hopkins Hospital, 1990). Even university schools of nursing are putting more emphasis on teaching skills for their students as evidenced by new course content (University of British Columbia School of Nursing, 1999).

Considering the ever-increasing cultural diversity, Canada's mosaic has been growing since its auspicious inception. This growth began with the blending of two European cultures and an indigenous people. From that point, an ever-increasing stream of individuals and families has come to Canada from all the countries of the world. They come for a variety of reasons, from refugees fleeing oppression to ordinary people looking for a new or better way of life. This stream of newcomers has not abated over the years. In fact, there has been an almost 15% increase in the number of immigrants living in Canada since 1991 (Statistics Canada, 1997a). Of late, there have been notable changes in the nature of the immigrant population, one of the most significant being the shift in source countries. Whereas in the past, British and European immigrants were by far the predominant peoples coming to Canada, today that demographic has evolved into a progressively growing portion of immigrants arriving from Asia and South America (Statistics Canada, 1997a). Actually, between 1991 and 1996 more than a million immigrants arrived in Canada and greater than half of them (57%) were Asian-born (Statistics Canada, 1997a). South and Central American immigrants comprised the third largest groups in that five-year period. Also in 1996 one out of every three people in
Vancouver was an immigrant and four out of every five newcomers were from Asia or the Middle East (Statistics Canada, 1997).

It is significant to note that over three-quarters of recent immigrants (1991-1996) have a mother tongue other than English (Statistics Canada, 1997b). In fact, in Vancouver, B.C. even fewer families are using English at home than in the past (Jimenez, 1998). Of course, as the number of non-English speaking individuals in Canada grows, it stands to reason that the amount of non-English speaking persons in need of health care would also grow. That is indeed what has occurred, as evidenced by innovations such as the Bridge Clinic at Mt. St. Joseph's Hospital Vancouver, B.C. This clinic has emerged to help meet the needs of new immigrants with health care concerns and no expertise in accessing the system. It attempts to bridge the gap and establish links between these individuals and appropriate health care providers. Also lending support to this phenomenon is the large-scale translation of patient information into Chinese for Vancouver Health Sciences funded by Hong Kong Bank and precipitated by the overwhelming numbers of Chinese patients requiring hospital services.

As this "new immigrant" phenomenon grows, our government's policies, both national and provincial, regarding the importance of health care delivery to all the residents of our country, begin to take on a new aspect. From a federal point of view, Section 36 (1) a of the Canadian Constitution, the preamble of the Canada Health Act, as well as the document Achieving Health for All (1986) speak to the goal of providing equality in health care for all Canadians. The statements in these documents reflect the need and desire for access to quality health care without undue barriers. The original goal, to ensure reasonable access to appropriate health care for all provinces and
territories as well as persons in rural and poor urban areas, has come to include both language and culture as potential barriers in addition to barriers such as distance and sparse population.

Considering the B. C. provincial perspective, two reports, Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs (1991) and Policy Frameworks on Designated Populations (1995) advocate effective delivery of equitable service for all persons. These reports also indicate that language barriers are an important issue in healthcare and even discuss concerns that immigrants do not receive the same standard of care as their Canadian-born counterparts. For nurses specifically, the Canadian Nurses Association Code of Ethics (Canadian Nurses Association, 1997) clearly states “nurses apply and promote principals of equity and fairness to assist patients in receiving unbiased treatment and a share of health services and resources proportionate to their needs” (p. 17).

At present, even at the level of individual institutions, it is clear hospitals and community health centres are working to try to provide quality care for all of their patients and families regardless of ethnicity or mother tongue. For example, the Board of Directors of Providence Healthcare and its administration have endorsed a statement of commitment from a Working Paper on Diversity that asserts it is "committed to providing high quality, compassionate health care to the diverse communities we serve..." (Diversity Steering Committee, 1999), p. 1). This document also states "everyone will have the same opportunity to access health care" (1999). In addition, several health care facilities in B.C.’s Lower Mainland have joined together with host centre Mt. St. Joseph’s Hospital to contribute to and support a multilingual health information website
(www.healthtrans.org). This website provides translations of health care information in a variety of languages.

It is clear that this laudable goal of equal access to health care for all people is a fundamental concept for Canadians. Despite this, there are a number of obvious difficulties in implementing this worthy objective. For example, how do health care providers assess the needs of non-English speaking patients when they cannot communicate effectively with them? How do health care professionals provide appropriate treatment, medication, instruction, and information to these patients without being understood, or without understanding the patients?

Within the scholarly literature, there is a large body of evidence that supports the concept of education as a useful and often crucial component in the care of patients. It has been shown to improve patient outcome, decrease complications, and improve overall sense of control and well being (Meeker, 1992; Lindroth, 1997; McMahon, Rizma, et al., 1997; Mullen, 1997; Klang, 1998). There is however, virtually no literature on the outcome or effectiveness of education for non-English speaking patients. In fact, in almost every case, those individuals that cannot communicate in the language of the host country are excluded as participants in studies (Anderson, 1996). Additionally, there is a dearth of material available on how educators can teach non-English speaking or limited English proficiency patients, what strategies are effective, or what materials are beneficial.

There are numerous examples of the negative outcomes associated with inadequate communication between patients and their health care providers (Inui and Carter 1985; Morris, Lucero, et al., 1989; McLeod & Shin, 1990). For example, a
pregnant Vietnamese woman who did not speak English was unable to explain to her doctor that she had been previously diagnosed with lupus. By the time her lupus was apparent to the medical team, the immune reaction was severe and despite an emergency abortion, the patient died (Walton, 1996). In another example, a South Asian man who had limited English proficiency was experiencing abdominal pain, and was unable to convey the severity and specific location of his pain to his doctor who relied on a documented history and assumed the pain was an exacerbation of previous back pain. It was not until his leg became cold and pulseless that he was evacuated by air to a larger center and an aortic clot was diagnosed and treated, but not in time to save his leg from amputation or his kidneys from failure (Needham & Wolff, 1990). The man was awarded $1.3 million for negligence.

Statement of Problem

An increasing number of patients who require education specific to their illness or injury are not English speaking as are the majority of health care educators. The paucity of research data associated with learning for non-English speaking patients (Anderson, Wiggans, et al., 1995) has resulted in few appropriate and effective strategies or methods for educating non-English speaking patients. Until more is known about methods of teaching for non-English speaking patients and the obstacles encountered by both the educator and the patient associated with language as a barrier, nurses are likely to provide inadequate services or inappropriate care to this vulnerable population.
Purpose

In this study, I explored the experience of nurses as they teach non-English speaking patients about an aspect of their illness or injury. Additionally, I explored strategies employed by these health care educators to address the learning needs of this population. I see this research as the first step in a project that over time will develop and evaluate specific strategies to overcome the issue of language as a barrier to patient education. The next step will be a similar study from the perspective of the limited English proficient and non-English speaking patients themselves.

Research Questions

1. What is the experience of educators teaching patients who are non-English speaking or have limited English proficiency?

2. What strategies have educators employed to try to facilitate learning for patients who are non-English speaking or have limited English proficiency?

3. What resources do educators need to provide effective teaching for patients who are non-English speaking or have limited English proficiency?

4. To what degree have any of these strategies (see #2) been effective?

Definition of Terms

The following are the definitions for terms used in this context of this paper:

Diversity: The condition or state of being different or having differences.

Ethnicity: A quality relating to a community or group whose members possess traits that are a product of common heredity or cultural tradition.

Nurse Educator: A nurse who provides illness or injury specific education for a patient in either a formal or informal setting.
Language: Words, pronunciation, methods of usage, that are employed and understood by a considerable community and established over a long period of time.

Limited English Proficient Patients: Patients who cannot completely comprehend or fully communicate in English.

Non-English Speaking Patients: Patients who cannot comprehend or communicate in English.

Patient Education: The process, content, context and strategies employed to enhance the knowledge, skills, attitude, and behavior of persons in need of nursing care. It may be formal or informal, individual or in groups.

Significance

The primary significance of this study is that it provides documented descriptions of what it is like to teach non-English speaking patients, the difficulties encountered by educators who teach such patients, and the perceived outcomes of this educational experience. These descriptions were useful in determining problems and positive aspects associated with such a situation, as well as in identifying strategies to minimize the effect of the language barrier on educational outcomes. In addition to the above mentioned significance, benefits of this study also include contributing to the embryonic body of research material on the subject of language barriers in patient education and the opportunity for frontline healthcare professionals to contribute to the expansion of nursing knowledge in their field of expertise.
Organization of Thesis

Within this chapter, I have presented the background to this proposal/study and the factors that contributed to its pursuit including the significance and purpose. In chapter two I reviewed pertinent data, including literature, both anecdotal and research-based as well as a presentation of my personal experience. In addition, I explored some research data that, although not specifically on point, has significant overlap with the subject of this study and contributed considerably to this study. This chapter also describes an analytic framework and asserts underlying assumptions. Chapter three consists of a discussion of the research method and design; including sample, setting, description of participants, generation and analysis of data, strategies to ensure rigor, ethical considerations, and potential limitations of the study. The findings of the study are presented in Chapter four. In Chapter five selected findings of the study, their implications for patient education and for future research are discussed. Chapter six concludes the thesis with a summary of the study and a review of its foremost conclusions and implications for the practice of patient education within nursing.
Chapter Two: Literature Review

In this chapter, I summarize and critique the present state of knowledge about the education of limited-English proficient and non-English speaking patients, the elements that contribute to the forestructure of this study, and finally the analytic framework that forms the basis of inquiry for this research.

Process

Despite the idea that qualitative investigators should approach their studies with a completely open mind and without any preconceived notions (Glaser & Strauss, 1967; Morse & Field, 1995), it is vital to link new ideas with established ones, gain an in-depth knowledge of the phenomenon under study and build on the knowledge of others. An appropriate way to accomplish this is a review of pertinent literature. According to Morse (1995) this review allows the researcher to show how the study will enhance the present state of knowledge and justify the selection of study topic. An examination of the state of knowledge on the topic under study also allows the researcher to place new ideas or concepts in context within the discipline (Hart, 1998). The data from the proposed study could in fact, be considered as contributing to the expansion of inquiry into the spheres of cross-cultural patient communication, education, and health care.

This chapter includes both scholarly and anecdotal literature as there is a paucity of directly related research and anecdotal accounts often reveal the frustrations and challenges of both educators and learners. Furthermore, given that I am the primary instrument of analysis, it is important to explore the elements that have come together to form my perspective and understanding of this subject (Lincoln & Guba, 1985).
Therefore, I also presented my own experience in this arena, along with my assumptions about the phenomenon under study.

The literature search was conducted by using the following keywords alone and in combination: patient education, client teaching, non-English speaking, limited-English proficient, language barriers, and barriers to healthcare. The search was conducted in the UBC Library catalogue and in the Ovid databases CINAHL, Medline, EMBASE, and Healthstar from 1985 forward. In addition, I searched the Education Index and ERIC databases under the following keywords: language, barriers, teaching, non-English speaking, and education.

It is important to note that there is little material available that is directly related to patient educators and patient education with persons who have limited-English proficiency or do not speak English at all. This is true of most scholarly literature and particularly so within nursing research literature. In searching the education literature, including material on the process of education, individual or learner-centered education and English as a second language, most information was concerned specifically with how to teach a new language as opposed to teaching concepts to a person who speaks a different language. As a matter of fact, I was unable to locate any material that discussed appropriate methods for educators to teach non-English speaking patients in either the health care or education literature. There does, however, appear to be a sizeable amount of material pertaining to culture and language and their effect on access to health care as well as the concept of cultural competency for nurses. As a result, I also explored this literature in an attempt to discover any parallels that might exist between language as a barrier to patient education and as a barrier to accessing health care.
Language and Patient Education

Most research articles on patient education ignore or actively exclude limited-English proficient and non-English speaking patients (see, for example, (Lindroth, 1997; Riesma, 1997; Klang, 1998; Schlatter, 1998)). One author, on examining cross-cultural perspectives in patient education, observes that limited-English proficient patients are often labeled as non-compliant or difficult (Tripp-Reimer & Afifi, 1989). This thought is echoed by Anderson and other experts in multicultural health (Anderson 1990; Marin, Burhansstipanov, et al., 1995; Anderson, 1996; Woloshin & Schwartz, 1996; Tang, 1999).

Several authors have commented that the majority of patient education programs have historically been developed by white health professionals primarily for white patients (Tripp-Reimer & Afifi, 1989; Woodruff, Candelaria, et al., 1996). Other authors explain that a major contributing factor to the success of ethnic self-help groups is that they are not attended to by a homogeneous professional class of care providers (Humphreys, Mavis, et al., 1994; Gosine, 1999). As one patient put it “I want them to stop hiring white mainstream blue-eyed multicultural workers and hire people in the community” (Office of Alcohol Drugs and Dependency Issues, 1998). The lack of ethnically diverse practitioners may contribute to a sense of alienation in our limited-English proficient and non-English speaking patients.

In terms of written material, several patient education studies show that many pamphlets and other patient handouts are not just ineffective, but in some instances, may lead to unintended outcomes in this population that is not able to fully comprehend written English (Glazer, Kirk, et al., 1996; Beaver & Luker, 1997; Wilson, 1997). To
illustrate, one author recounted the story of a 30-year-old pregnant diabetic who was given instructions to take a 30-minute sitz bath twice a day for swelling. On a return visit to her practitioner, the patient said how proud she was to be able to complete her sitz baths as they exhausted her so much. She had interpreted the instructions to mean that she was required to sit down and stand up continuously for the entire 30 minutes twice each day (Haffner, 1992). There are countless examples of similar cases, some with dire consequences. In fact, one author in a study on illness in first generation Canadian women states “lack of adequate interpreter services in many institutions puts some groups at risk and raises a fundamental question of safe health care (Anderson, 1998, p.206). These incidents and concerns support the need to address the issue of language as well as translation of health care materials. In many health care institutions, literal translations from English pamphlets into other languages are the only form of patient education available to limited-English proficient and non-English speaking patients. Unfortunately, the vocabulary and meaning are often incorrect and even more unclear in the translated version than in the original English version (Baker, Parker, et al., 1996; Galanti, 1997; Riddick, 1998). For example, in an article on implications of health education for Hispanic women, a pamphlet on cervical cancer is highlighted as describing a vaginal smear as a “fat” test thereby misleading the women as to the significance of the test (Morris, Lucero, et al., 1989). The problem of inaccurately translated words may lead to obvious confusion, but more insidious is the tendency for patients, even those that maybe well-educated, to dismiss the information as unreliable or irrelevant. It is clear that more study is needed in this area to determine the most appropriate format and best use of handout materials for limited-English proficient and non-English speaking patients.
In the only research of its kind that I was able to discover, one study employed a random convenience sample of parent groups (equal numbers of Spanish and English-speaking participants) to determine if errors in dosing liquid medication could be decreased through education (McMahon, Rizma, et al., 1997). In addition to showing that instruction decreased errors significantly, when the optimum instructional strategy was provided in the patient's primary language, fully 100% of the parents, both English and Spanish-speaking, were able to dose the medication correctly (1997). Although not the primary intent of this study, the results tend to suggest that use of patients' first language for education and instruction could improve patients' understanding and potentially affect health outcomes.

The sources for much of the material in this next section are textbooks on patient education. Although a large number of educational strategies are proffered within these textbooks, a tacit underlying assumption of most texts appears to be that all patients comprehend English. The implication is that educators need be concerned simply with an acknowledgement of increasing cultural diversity and the need for sensitivity, and not with specific language issues (Babcock & Miller, 1994; Ferran, Tracy, et al., 1999). Some educational strategies recommended by authors of patient education texts are shared goal setting, contracting, and follow-up phone calls (Redman, 1997; Close, 1998). Even though these actions may be effective approaches for many patients they are all but useless for limited or non-English speaking patients as these strategies require English comprehension and proficiency or, conversely, the ability to competently speak the patient's language.
Other strategies proposed by these authors deal only with how an educator's awareness of ethnic health care beliefs and practices can facilitate discussion with ethnically diverse patients about treatments and expectations (Pauwels, 1995; Spector, 1996; Galanti, 1997). Again, strategies that enhance discussion with ethnically diverse patients are laudable, but applicable only after effective two-way communication has been established. The issue of educators having to teach patients with limited-English proficiency does not appear, to this point, to be addressed within the current literature. Perhaps this is the case because in the not so distant past, the numbers of non-English speaking patients were small and therefore did not present the challenge to patient educators that exist today. Or possibly, it is the increasing numbers of limited English proficient and non-English speaking patients that have served to highlight the apparent inequality of the status quo. It is also likely, that this lack of attention to teaching limited English proficient patients may be seen by many as a cross-cultural issue and therefore considered a concern to be addressed within a specific specialty as opposed to within the sphere of general nursing.

The small number of articles and even fewer studies related to the education of limited English proficient and non-English speaking patients led me to seek another area of patient care that had experienced similar concerns or had conditions that might parallel those in patient education. One such area was that of access to health care for ethnically diverse patients. Not only was this an aspect of patient care that might mirror situations encountered in patient education, but this particular topic is one that is significantly represented in current nursing literature. Hence, what follows is an exploration of the current literature on the effect of language on access to health care.
Language and Access to Health Care

Much of the discussion within the literature concerning diversity of language and access to health care focuses around the patient's inability to communicate effectively, as well as patients' lack of knowledge about their specific illness, injury, or treatment. For example, there is a significant body of literature concerning if and when language service is appropriate or warranted in health care agencies, legal issues related to informed consent and Human Rights legislation, equality of treatment, and the financial cost related to language services (Manson, 1988; Ministry of Health and Ministry Responsible for Seniors, 1995; Zahn, Cloutterbuck, et al., 1998; Tang, 1999). There is also a smaller body of literature identifying how language influences the patient-provider relationship. Some authors describe practitioners' frustration in trying to establish rapport with limited-English proficient and non-English speaking patients and the subsequent errors generated because the patient cannot speak or understand English (Johnson, Anderson, et al., 1995). In a study employing a cross-sectional survey in an emergency department, another author describes how communicating through an untrained interpreter interferes not only with information exchange, but also with building a trusting relationship with the patient (Baker, Parker, et al., 1996). This study also highlighted the fact that not having an interpreter greatly affected the patients' perceived knowledge of their diagnoses and treatments.

Scholars who have investigated barriers to accessing health care have focused primarily on: 1) the consequences of being a limited-English proficient or non-English speaking person in need of health care and 2) strategies that could overcome barriers to accessing health care. A major consideration in this regard is language.
occupies prominent positioning in the list of barriers to health care access that have been generated from research, with cultural considerations also assuming high priority. It is difficult to discuss language as a barrier without also discussing culture, as the subject of language is inexorably enmeshed in the issue of culture. Although it can be problematic to contemplate the ramifications of language without considering the influence of culture, I have limited, in this study, the discussion of culture to a generic element that shapes all languages in some manner, rather than concentrating on specific differences within each culture.

Spector in *Cultural Diversity in Heath and Illness* (Spector, 1996) maintains that language barrier may be the most significant obstacle to multicultural health care because it affects all stages of the patient-provider relationship. Mensah, (1989) from Dalhousie, notes the abundant problems associated with communication and translation and the large number of case studies that illustrate language issues for patients. Communication is a key aspect of this discussion because if either the patient or the nurse become frustrated with an interaction due to an inability to share ideas or information, the processes of diagnosis, treatment, and education become evermore problematic. In other words, the nurse is rendered unable to establish a therapeutic relationship or to determine the patients’ specific needs. It is clear, therefore, that unless nurses can effectively communicate with patients, they are unable to assume patients ascribe to any particular health or illness belief simply by virtue of their apparent ethnicity.

Many authors have suggested that immigrants and other limited-English proficient persons access health care to a lesser extent than non-immigrants (Anderson, Blue, et al., 1993; Tang ,1999); Riddick, 1999). It has been hypothesized that this is a
direct result of a variety of barriers that exist for this population in accessing health care, the most formidable being language (McInnes Consulting, 1997; Torres, 1998). Several authors have determined that due to an inability to communicate effectively, patients have been misdiagnosed, have misunderstood treatment directions, have lower levels of satisfaction with the health care they received, and have often been unable to build a trusting therapeutic relationship with their practitioner. For example, in a large study of 2333 patients using a cross-sectional survey and follow-up interviews, the authors found that non-English speakers were less satisfied with their care in the Emergency Department, less willing to return, and reported more problems with their emergency care (Woloshin, 1995; Torres, 1998; Carrasguillo, Orav, et al., 1999). In a paper presented at a forum on Language Barriers to Care, (Torres, 1998) the author states that when interpretation falls to “anyone who is bilingual such as an employee, family member or friend...this often leads to inaccuracies, failure to disclose information, violation of confidentiality and failure to develop rapport with patient” (p. S23). Several physicians, in a letter to the editor in JAMA about a case of a non-English-speaking Laotian women who underwent an extensive work-up for elusive symptoms, drew attention to the fact that both the doctor and the patient were at significant disadvantage due to the lack of a common language (Woloshin and Schwartz 1996). This prevented the patient from adequately expressing her concerns or describing her symptoms and prevented the physician from exploring the patient’s pertinent history (Woloshin & Schwartz,). These physicians argued that “effective interpretation is a prerequisite to ensuring that persons with limited English proficiency get the service they need and only the services they need” (p. 684).
Additional issues, regarding language concordance of patients and health care professionals, have been addressed in several studies. Researchers using a retrospective cohort study concluded that Hispanics with long-bone fractures are twice as likely as non-Hispanic whites to receive no pain medication in the emergency center studied (Todd, Samaroo, et al., 1993). Also, Perez-Stable, Napoles-Springer, and Miramontes, (1997) in a study using a questionnaire administered to a stratified random sample of patients, were able to demonstrate that ethnicity was an independent predictor of some specific health status measures and of specialty clinic visits in one year. One researcher (Manson, 1988; Perez-Stable, Napoles-Springer, et al.) employing a chart review of 96 patients was able to show that patients with language concordant physicians were more likely to be compliant than those with language discordant physicians. In addition, a trend was noted that patients with language discordant physicians were more likely to attend the emergency department. Together these studies begin to illustrate that as a result of inadequate communication, limited-English proficient and non-English speaking patients may have confusion regarding diagnosis, treatment, and follow-up and in some cases possible increased morbidity.

A variety of strategies have been offered by researchers and scholars to overcome the barrier of language in accessing appropriate health care:

1. Provide language services in the patient’s language (Corkery, Palmer, et al., 1997)

2. Hire bilingual providers, establish “bridge” workers or bilingual aides (Gosine, 1999)

3. Use visual clues, stories, or aids (Murty, 1998)
4. Train current providers in languages (Riddick, 1999)

5. Involve peer support models/volunteers (Morris, Lucero, et al., 1989)


7. Adopt new methods of delivery -- groups, visual media, or collaboration with ethnic healers -- (Office of Alcohol Drugs and Dependency Issues, 1998)

8. Establish ethnic specific clinics (Sent, Ballem, et al., 1998)

Strategies offered by some authors (such as those in school based or health promotion programs) that were not likely to be applicable to patient education in any significant way are therefore not included here. As well, a number of strategies more specific to mass health education and that apply more specifically to health promotion for diverse cultures (i.e. community outreach programs, poster campaigns) were evident, but is not examined in this paper (Marin, Burhansstipanov, et al., 1995; Zahn, Clutterbuck, et al., 1998).

Some of the aforementioned strategies are self-explanatory, while others require further elaboration. The most commonly recommended strategy is provision of language service. This usually involves interpretation and translation. A number of authors have examined the use of language services and have determined this service is essential for adequate health care. As previously noted (Manson, 1988; Baker, Parker, et al., 1996; Carrasguillo, Orav, et al., 1999), the effectiveness of using interpreters was confirmed in three separate studies of emergency room care. Another investigator discovered that language discordance was a significant factor in deterring women from screening tests for breast cancer (Beaver & Luker, 1997). The women, from a variety of ethnic origins,
were unable to decipher the information in the pamphlets and brochures on the purpose of
the testing or the procedures to follow. In addition, translations were often erroneous,
increasing the misunderstanding and confusion. In a qualitative study that used focus
group discussion investigators discovered that, contrary to popular belief, women from
ethnic minorities were not adverse to cervical cancer screening once they understood the
purpose and procedures involved (Naish, Brown, et al., 1994). In fact, these same
researchers found that attitudinal barriers and fear of cancer were not deterrents, but
language and administrative barriers were. In this study, use of bilingual health workers
to facilitate access and to increase understanding of information was another successful
strategy employed to improve the accessibility and outcome of health care for limited-
English proficient and non-English speaking patients. These workers were bilingual,
bicultural members of the community and served as connectors and liaisons between
patients and health care providers. They reinforced instructions, rescheduled
appointments, and assisted when difficulties arose.

Other strategies discussed include non-traditional and innovative teaching
methods such as enhanced visual aids, illustrations, storytelling, and peer counselors. In
an article concerning intervention during and after pregnancy, the authors describe the
use of the Hawaiian “talkstory” and its integration into a successful health care strategy
for pregnant women (Affonso, Mayberry, et al., 1996). In another article, the authors
identify helpful educational strategies, among them are storytelling, folktales, and use of
culturally appropriate visuals (Tripp-Reimer & Afifi, 1989). Another author, in an article
that describes an educational outreach program for immigrant women, stresses the need
for innovative approaches to education, such as visual displays and illustrations, as well
as ample time to achieve educational goals (Murty, 1998). Authors of some studies that examined health education within the domain of health promotion for diverse cultures proposed a variety of strategies. Many of these paralleled strategies already mentioned such as peer support and the use of interpreters. (Marin, Burhansstipanov, et al., 1995; Zahn, Clutterbuck, et al., 1998) in an article that summarized the outcome of health education efforts for populations that have limited services, reiterated the importance of training health care providers, cooperation between traditional healers and health providers as well as incorporating non-traditional approaches. Other strategies such as the use of mass media and community organizations were not applicable to this topic of patient education. Most recommendations by authors consider strategies they have tried in their personal practice; these strategies are not necessarily research-based. There is a decided lack of evaluative research about when and if these strategies affect the desired outcomes.

There are many papers, books, and articles that discuss the low usage of health services by limited English proficient and non-English speaking patients. Most often authors attribute this underuse to either fear of misunderstanding or misinterpretation (Anderson, Blue, et al., 1991; Pauwels, 1995; Anderson, 1996; Spector, 1996; Galanti, 1997). One author, whose book consists of an in-depth study of a single case, attributes the underuse of the health care system, in part, to lack of regard by medical and nursing personnel for the spiritual beliefs within a culture that members believe to be intrinsic to health. This apparent lack of regard or dismissal of cultural beliefs as useless or unimportant serves to alienate members of a specific group as much as difficulty in communicating (Fadiman, 1997).
Several authors (Kramer, Ivey, et al., 1999); (Marin, Burhansstipanov, et al., 1995) in listing the many barriers to accessing health care, legal, cultural, systemic, financial, consider language the most formidable. Perhaps because it is the most basic and pervasive of the barriers and two-way communication is essential to optimum outcomes. The inability of these patients to explain their complaints, needs, concerns, and symptoms to health care professionals not only allows a problem to persist and possibly intensify but increases the patients' sense of fear and inadequacy. To illustrate, one patient said

I found bleeding when I had a bowel movement I worried and wanted to talk to my doctor in English. My daughter is far away and she has to make long-distance phone call which is expensive since she has little money. I do not want to bother her. But I worry and hope it is not a serious problem (Zahn, Cloutterbuck, et al., 1998).

Clearly this patient struggles with her inability to speak directly with the doctor and it causes her to put off seeing him, increases her fear for her health and promotes guilt for costing her daughter money. There are numerous such examples permeating the literature (Pauwels, 1995; Spector, 1996). In one previously mentioned U.S. study (McMahon, Rizma, et al., 1997), the authors demonstrated that education could decrease dosing errors for parents administering medication to children also found that when appropriate education is provided in a patient's first language there is no difference between English-speaking or Spanish-speaking parents in dosing medication. In fact, in the group that received a marked syringe, demonstration, and instruction, all parents (100%) correctly administered the medication regardless of their primary language.
(McMahon, et al.). Thus, it appears possible that if appropriate strategies can be employed for this target population, compliance could be increased and therefore health outcomes might improve.

Also within the professional literature, a plethora of books and articles on cross-cultural nursing abound and, almost without exception, tend to ignore patient education as an aspect of patient care. In each of these books, language is consistently listed as a barrier to health care and many examples and case studies are presented to illustrate negative outcomes of language as a clinical obstacle (Mensah, 1989; Galanti, 1997); (Simmons, Vaughn, et al., 1983; Spector, 1996). However, other than describing the drawbacks of a variety of interpretation modes, the authors of these writings do not propose a plan or approach for practitioners to surmount language barriers. One notable exception is a chapter by Riddick, (1999) in Immigrant Women’s Health that itemizes several common strategies that were gathered from a several national health surveys, reports of advocacy groups, and state and territorial reports on health care practices. Many of these strategies mirror those presented in the last section. In particular, Riddick details the types of interpretation that are frequently used in health care. The most common method employed is that of the ad hoc interpreter. This untrained person can be anyone from a family member (including children) or friend, to a staff member. Although this may be an expedient response to the difficulty of language, this method is fraught with problems, particularly the patient’s loss of privacy and confidentiality as well as the likely reluctance to divulge personal, but crucial information (Phelan & Parkman, 1995; Anderson, Tang, et al., 1999). In addition, the seriousness and frequency of errors in this method of interpretation suggest that this approach be employed only in
the absence of any other viable alternative and never as a first option (Vasquez & Javier, 1991; Torres, 1998). Other concerns about this mode of interpretation include translator discomfort with sexual or gynecological information and the precarious effect of family dynamics on transmission of information (Ministry of Health and Ministry Responsible for Seniors, 1995).

Another source of interpreters is a volunteer language bank. Volunteers in a language bank undergo some training and provide assistance when needed. The major drawback to this system is the lack of medical knowledge and the lack of professionalism among some volunteers. Frequently, a volunteer translator and patient become involved in a discussion with the nurse having no knowledge of what is actually being said by either the patient or the interpreter. In addition, the volunteer can have strong personal reasons for providing translation that are unknown to either the patient or the provider (Friend, 1991). The most appropriate solution for many practitioners and patients is the use of professional medical interpreters. However even this strategy can generate concerns, including the high cost of this service, as well as the addition of another person whose participation may interfere with the development of a therapeutic relationship (Barton & Brown, 1992; Chang & Frotier, 1998). Barton & Brown, (1992) in a qualitative descriptive study of 13 nursing students discovered that communicating through an interpreter interfered with the students’ ability to build a trusting relationship with their patients. A variation on the use of trained interpreters may include an AT&T distance interpreter (Pointon, 1996) or remote simultaneous interpretation as studied by Hornberger et al. (Hornberger, Gibson, et al., 1996).
Another aspect of language service is the provision of translated written material. Although little research has been conducted about the efficacy of such resources, it is generally agreed that these can be useful if tailored to the appropriate reading level of the patient and adapted for cultural appropriateness (Riddick, 1998). Diagrams, graphics, and pictures can also be used to enhance the written message (Wilson, 1997).

Many authors note that for these or any strategies to be implemented within a health care system all the stakeholders must consider the goals to be a priority (Anderson, Tang, et al., 1999; McInnes Consulting, 1997; Riddick, 1999; Johnson, Anderson, et al., 1995; Masi, 1996). In a final report on multicultural change and health services, key observations included the importance of agency-based commitment and support. This commitment included broad-based visible senior management support in all areas, administration, physicians, nurses, unions, and hospital boards. Resource commitments consisted of financial commitment for staff, training, program development, initiation, and continued implementation (McInnes Consulting, 1997). Ideas alone cannot facilitate change; an appropriate infrastructure must be developed by those with the responsibility, commitment, and vision for the future.

Summary of Literature Review

Clearly there is a significant lack of literature concerning language as a barrier to patient education. However, I believe that the above discussion illustrates the issues of language that make accessing health care difficult and are, if not identical, at least similar, to the issues that create difficulty for limited English proficient and non-English speaking patients that need education to adequately understand their disease/injury and to fully participate in their care. With the experience of these researchers and scholars as a
foundation, appropriate comparisons and contrasts have been made to the data collected from patient educators who participated in this study. This data contributed to the analytic framework that provides a basis for assessment, evaluation, and interpretation of subsequent data.

Forestructure

The forestructure of this study consists of a combination of my personal experiences and the assumptions that form the basis of the study. These two factors are now presented in detail.

Personal Experience

As previously noted in Chapter one, I was most recently an educator in Nephrology and in this capacity encountered many non-English speaking and limited-English proficient patients. During this time, I became increasingly concerned with the apparently poor level of understanding the patients had achieved with my tutelage. Unable to find any information to aid my teaching, I tried many alternative strategies to enhance patient understanding. These ranged from the use of videos with dubbed translations, family members and friends or volunteers to interpret, an informal type of sign language, a professional interpreter (extremely limited), all the way to making up stories and drawing pictures. Many problems became evident to me while trying to teach non-English speaking and limited-English proficient patients. Most significant was realizing that patients would seldom indicate that they did not understand what was being discussed, despite direct questions. It was only with increased time and establishment of rapport that I was able to realize patients often felt that they would be seen as "stupid" or poorly educated, if they let on that they did not understand. Sometimes the patients were
acting within a cultural norm and being polite or humble when they indicated “yes” they understood. Also many patients felt they did not deserve the “extra” time it would take an educator to explain things in more detail. During my experience as educator, the patients also taught me some things about their own beliefs. For example, for some patients to speak of illness gives power to the illness, hence, they are reluctant to discuss any questions they might have. I also learned in some instances there are rituals that have influence over illness and therefore issues such as the timing of treatments may be affected.

It became increasingly clear that more was needed to meet the needs of these patients. Despite attempting many teaching options, I never really felt that these patients had achieved the same level of understanding, as had their English-speaking counterparts. I felt disillusioned and inadequate. Consequently, it became apparent to me that more research needs to be done in this area.

Assumptions

Because the knower cannot be separated from what is known (Lincoln & Guba, 1985) it is important to be cognizant of the factors that influence me. Among these factors are the assumptions that I have established as a basis for this research study. The following is a list of those assumptions:

1. Patient education can improve health care outcomes.
2. All patients are entitled to effective communication with health care providers.
3. Patients’ first language, as well as their cultural beliefs, affect their understanding of disease process and treatments.
4. Inability to communicate effectively interferes with the ability to achieve high-quality health care for both caregivers and recipients.

All these sources of knowledge, that is, pertinent literature, personal experience, and assumptions, have contributed to the development of a framework that guided my inquiries into the research topic.

Analytic Framework

The use of an analytic framework is encouraged by the method with which I have chosen to pursue this study, namely, interpretive description. As noted by the authors of this qualitative method, an interpretive description should be located within existing knowledge in order that findings can be linked to those of others in the field and thereby promote greater knowledge of the particular phenomenon (Thorne, Reimer Kirkham et al. 1997). Additionally, rather than a formal conceptual framework, as in traditional descriptive studies, these same authors suggest that an analytic framework built from a critical analysis of the current knowledge is appropriate. Therefore, this is the path upon which I embarked to construct my analytical framework. I did, however, use a traditional approach to anchor the analytic framework. It was centered on the tradition of Naturalistic Inquiry as set forth by Lincoln and Guba (1985). The ontology (nature of reality) of this tradition is that multiple realities exist and that although we are not able to predict or control these realities we are at some level able to understand these realities (Lincoln & Guba). It is this understanding or knowing that enables us as educators to develop and implement appropriate strategies to teach limited-English proficient and non-English speaking patients.
In critically examining the aforementioned literature, these predominant themes emerged: (1) the importance of, and variation in, language service, (2) a need to identify/develop specific educational strategies to overcome the language barrier, and (3) need to identify and affect institutional factors that influence patient education. In order to pursue these themes, a more concrete analytic framework is required. The following (Figure 1) is a schematic representation of the framework derived from the aforementioned literature, my personal experience and assumptions. This framework also identifies some attributes that limited-English proficient and non-English speaking patients and nurse educators might bring to the educational encounter that influence the learning outcomes of that encounter. It illustrates three major elements that can influence the cross-language experience, institutional infrastructure, language service, and educational strategies.

The framework also depicts some specific factors within these major elements that contribute to their influence. This framework has guided the development of the interview trigger questions and the initial focus of inquiry, in that the questions and line of inquiry initially pursued the three major themes. However, I used the data obtained from the participants to focus, reform, and test this framework particularly, because this framework was constructed in part from the literature review, which focused on access to health care by non-English speaking patients. Besides data collection, this framework also aided in the analysis of this study by helping to organize the break up/down of the data into like categories. Therefore, while this framework was employed to guide this study, the researcher (myself), had to be willing and able to adapt and restructure the framework as needed. If, the participants identify additional or even totally different
elements that affect language as a barrier to patient education, the framework was to be
adjusted accordingly. Thus, there exists a reciprocal aspect to the employment of this
framework within the study. On one hand, the framework helps to guide the inquiry,
while on the other hand the study tested the validity and applicability of the framework.

Having concluded the literature review, presentation of personal experience and
pertinent assumptions as well as the formation of the analytical framework, the following
chapter discusses my study design and method of analysis for this study.
Chapter Three: Research Method

In this chapter I present the research method employed in this study. I have chosen an interpretive description design and discuss this method as it applies to selection of sample, data collection, and analysis. I also submitted the precautions used to ensure rigor throughout the study. Lastly, ethical considerations and limitations to the study are presented.

Research Design

This qualitative research study employed a descriptive interpretive method to pursue its questions. Interpretive description is a research method gaining popularity among nurse researcher and graduate students in many countries who are eager to link research into human health and illness with developing nursing knowledge in order to advance clinical practice. In addition, the popularity of this method may be related to the fact that it was developed by nurses for nurses and there are few methods that can claim this asset. For this study, as in most qualitative studies, the researcher aimed to discover the nature of the phenomenon under study from the perspective of the individual participants experience. To do this, interpretive description employs inductive reasoning. It is the participants' experience of events and situations that influence each of their individual behaviors, and that in turn helps to direct the method and allow the behavior to be seen as meaningful or making sense in light of its context. This constructed and contextual view implies that no one truth or any single interpretation of an event, situation, or text is the only correct one and this view dovetails well with the multiple realities of the tradition of Naturalistic Inquiry that drives this research (Lincoln and Guba 1985). Simply put, I attempted to
make sense of the phenomenon and participants’ experiences in terms of the meanings that participants brought to them. Despite the uniqueness of each participant’s experience, I made use of this design to search for commonalities and shared responses among the participants in order to facilitate understanding the phenomenon under study.

I consider naturalistic inquiry and interpretive description to be a good fit, as naturalistic inquiry focuses on describing characteristics of social interaction or phenomena (Creswell, 1998) and interpretive description is an appropriate method to explore phenomena when little is known about the subject (Thorne, Reimer Kirkham, et al., 1997; Creswell, 1998). Naturalistic inquiry has its roots in qualitative rather than quantitative research (Mellon, 1990). The purpose of this inquiry is to understand how and why the interaction takes place as it does as opposed to trying to control the interaction (Gorman & Clayton 1998).

A first step in developing nursing knowledge is to be able to describe or identify the nature and attributes of the relationship under study (Burns & Grove, 1997). In this case, it is the relationship between the educator and the limited English proficient and non-English speaking patient that is being examined. With this research, I aimed to describe the educators’ experience of language as a barrier to patient education for limited English proficient and non-English speaking patients in our predominantly English speaking healthcare system. In addition, I explored what strategies are being employed to overcome this barrier and to what degree the educators perceive them as successful.
Participant Selection

Rationale

No specific formulas exist to determine the correct number of participants for a sample in a qualitative study (Morse, 1991). Nonetheless, due to the intensity and focus of one-to-one interviews, the stories told, and the abundance of unique and rich data that is generated, the sample in qualitative research is necessarily much smaller than in quantitative studies. A common approach to achieve an adequate sample size in qualitative research is to collect data until redundancy occurs or no new data emerge (Oiler, Boyd, and Munhill, 1993). Pertinent literature suggests that an adequate sample could vary from one (in a case study) to as many as a dozen or more depending on the goal of the study (Sandelowski, 1995). This small sample size and the intense time and attention demanded in data collection as well as data analysis require that participants be not only cooperative, but extremely knowledgeable about the subject in question. Participants must also be willing to share and expand on their experiences. Because of this necessarily small sample size, participant selection must obtain good range and richness of experience. Therefore purposeful sampling, the selection of participants in order to provide the most variation and richness of data within the small sample size was used in this study. Thus, participants were selected for their ability to meet the needs of the study, that is, to share what it is like to teach non-English speaking patients within their specialty and type of practice (Glaser & Strauss, 1967; Morse, 1986; Morse, 1991).
Inclusion Criteria

Criteria for inclusion in the study were: participants are nurse educators who practice in the Lower Mainland, have been involved in education of limited English proficient and non-English speaking patients for greater than two years and speak and read English. Persons excluded from the study were those that did not meet the inclusion criteria.

Process for Selection of Participants

Seven participants were selected from a list obtained from directors of patient education programs throughout the Lower Mainland. These directors were asked to suggest names of nurses that have had the greatest experience with limited English proficient and non-English speaking patients and are interested in sharing their knowledge and experience with others. Once a name was put forward a letter of invitation (Appendix A) was sent to the individual. From the participants who responded in the affirmative the researcher selected individuals, considering variety of work setting (i.e. tertiary care, community care) and diversity of program (i.e. renal, cardiac, diabetic), and contacted the potential participant to make an appointment to discuss the study, answer any questions, and obtain consent (Appendix B). When the subject consented to participate in the study, at this point, a time and place was arranged for an interview. Tentative timing for a focus group was also discussed at this time, as the same participants were involved.
Data Collection

All inquiry is influenced by the method that guides the investigative process of the problem. In this case, the use of interpretive description has engendered the development of an analytic framework that has in turn influenced both the choice of techniques for data collection and the focus of interview trigger questions (see Appendix C). Data collection included a single one-to-one interview for each participant and a follow-up focus group consisting of interview participants, both of which were conducted by the researcher.

As listed above, two of the four most common tools (observation, interviewing, group discussion, and historical study) of qualitative investigation were employed in this research. The use of these two tools has different, albeit complementary, goals. The first technique, interviewing, is designed to gather rich detailed information from participants who are experts in the education of limited English proficient and non-English speaking patients by virtue of their experience and knowledge. This technique was chosen to help explore the nature of the participants' experience and allow the participants more control over the direction and content of their stories. The primary method of inquiry (with the exception of demographic information) is that of open-ended questions. These types of questions are less threatening than direct closed questions and enhance participant comfort and disclosure (Morse and Field 1995). With use of open-ended questions, I encouraged the participants to highlight their own personal experiences and to share any feelings or insights that may have had an impact on their educational relationship with these particular patients. Through active listening and the consistent use of open-ended
questions, I was able to ascertain the context and nature of the educators' experience of language as a barrier to patient education. In addition, I was able to discover many strategies that were employed by the educators to surmount the barrier of language. Each one-to-one interview was approximately one hour in length, held in a location and at a time chosen by the participant. Each interview was audio taped and transcribed. The interview began by asking each participant what their experience of teaching limited English proficient and non-English speaking patients had been. A series of trigger questions was available to facilitate further discussion as needed (see Appendix C)

The second data collection tool to be employed in this study was a focus group. This group inquiry and discussion encompassed two objectives. The first was to disseminate the primary findings to the participants and the second was to discuss, clarify, and validate these same findings. Often data and insights not likely to be elicited in an individual interview can be expected from the increased spontaneity and candor of group interaction (Reed & Roskell, 1997). The focus group was also audio taped and transcribed. Field notes were made and I kept a journal throughout the data collection process. The field notes and journal were considered data and subject to analysis. In addition, two post-interview telephone calls were used to clarify points. These conversations were not transcribed but notes were taken and were considered part of the data for analysis.
Data Analysis

The primary data analysis, categorization and determination of themes, was done independently of the analytic framework as was the presentation of the findings. All data was analyzed on an ongoing basis using constant comparative analysis along with deep immersion in the data (repeated readings without coding). After I felt fully immersed in the data, themes and categories emerged and were noted. All subsequent data was then compared to the initial themes and categories to determine similarity or difference, to broaden, or limit, or to refine initial and ongoing themes and categories. As the data were reconfigured and analyzed they were interpreted independently from the analytic framework previously described. The data were then interpreted and described based on the analysis and in conjunction with the analytical framework. The themes and categories were used to highlight the commonalities as they reflected the participant experiences. Common themes or categories, shared behaviors, and patterns emerged and using inductive reasoning were analyzed (Sandelowski, 1995). As well, various rationale were considered in order to explain any significant individual differences or outliers within the data. When all interviews were completed, a focus group was held with the participants to share preliminary findings with the participants. The preliminary findings were examined and validated in discussion with the participants. Comments, concerns, and developments from the focus group were then analyzed, included with previous data, and incorporated into the study's findings. In the discussion section of the paper, the analytic framework was challenged by the findings. A comparison of the findings was made with the previously developed analytic framework and although many similarities were
evident, variations in the emphasis and importance of many factors were noted. From this challenge, a new framework emerged that more accurately reflected the findings of this study and relate specifically to the education of non-English speaking patients.

**Rigor**

Sandelowski (1993) explains that trustworthiness occurs when a researcher is seen to have made both process and practice visible, clear, and therefore auditable. She goes on further to state “it is less a matter of claiming to be right about a phenomenon than of having practiced good science” (p.2). To this end, I employed a tradition that has been recognized by nursing scholars and practiced by many researchers over time. As well, “interpretive description” is a uniquely nursing method that has been employed by increasing numbers of students and researchers. My research was designed, in part, to provide a clear audit trail for data collection, analysis, and interpretation. One strategy that facilitated this is the aforementioned personal journal that was kept for notes and jottings during data collection and analysis. As well, all analysis was ongoing according to the basic outline in Corbin and Strauss (1990) for constant comparative analysis.

Another strategy to establish a foundation for credibility was the plan to employ “thick rich description” from the raw data as well as, using quotes to illustrate findings. The findings from this study constitute the “essence” of the phenomenon described by the participants. Also inherent in this design was the opportunity for participant checking, in that preliminary findings disseminated and discussed in a group forum. This not only allowed the participants to share in the findings but also
contribute to the overall credibility and confirmability of this study. These findings are not necessarily generalizable owing to the fundamental naturalistic belief in multiple and constructed realities that precludes direct transferability. Despite this, I do believe the findings of this study has informed our practice by highlighting the experiences of these educators and allow us to reflect on the barrier that language presents to patient education as well as allow us to consider the factors that affect its continued presence. In addition, I feel that these findings have contributed to an area of nursing knowledge that researchers have yet to fully explore and that this knowledge has the potential to reduce the effect of language as a barrier and, thereby, affect nursing practice in a meaningful way.

**Ethical Considerations**

The major ethical considerations for this study are the rights and fair treatment of the participants. These were ensured by using a series of strategies including:

1) University of British Columbia Behavioral Ethics Research Board written approval to conduct this study.

2) Informed written consent for participation in the study was obtained from each participant prior to any study activity. Full disclosure of study purpose, activities, data collection, use, and dissemination of findings, and measures to ensure confidentiality, and ability to withdraw at any time without prejudice are specified in the Invitation to Participate (see Appendix A) and the Consent Form (See Appendix B). Consent is considered an ongoing process and was revisited as necessary.
3) In order to preserve confidentiality; tapes, transcripts, notes and discs, when not in use, were kept locked up and the key held by the researcher. Code numbers were assigned to each participant and used throughout data transcription and analysis. No names or specific identifiable qualifiers were used as descriptors in reporting the results. Research findings may be published, but participant's names will not be associated with the study. Contact information for participants was stored separately from data and kept under lock and key. Data may be used for secondary analysis. Tapes and transcripts will be stored for a period of 10 years and then destroyed.

4) Participants will receive a summary of study results at conclusion of the study upon request.

Limitations

The most significant limitations to this study relate to the inexperience of the researcher and the generalizability of the findings. My lack of experience may have affected the depth, breath, and the overall quality of the interviews as well as the data analysis and interpretation. The findings of this study are only representative of the educators interviewed. The fact of who was represented is due in part, to the discretion and decision-making of the program directors who nominated participants as well as the volunteer nature of the sample. Despite this purposeful sample, an educator may have been missed or may have declined to participate.

Considering the researcher as the primary tool of investigation, another potential limitation to this study is my previous exposure to this subject matter. This experience, although it may assist credibility (see previous section), has the potential
to cause the development of a personal bias and an *a priori* agenda. For me, the most important deterrent to this prospect is the construction of an analytic framework. Its development brought about an in depth examination of the literature and in many ways opened my eyes to a variety of alternatives and possibilities. It dissolved some pre-conceived notions that I was previously unaware I possessed. Hence, despite the fact that a researcher cannot be fully bracketed from her research, I feel that I attained a much more balanced and open-minded approach to this study. In addition, journaling as an ongoing effort assisted in recognizing bias as much as is possible.

Also, as regards the analytic framework, there is a danger that a researcher may depend too heavily on a constructed framework and inhibit other pathways that may be more data driven and reflective of the unique nature of the data generated (Thorne, Reimer Kirkham et al. 1997). My acknowledgement and awareness of this risk, as well as the aforementioned triangulation did serve to lessen the occurrence of this risk.

**Summary**

This chapter has described my research design, the participant sample and selection, data collection method, process and analysis. It has also addressed the question of rigor in detail and described ethical precautions. In addition, the limitations of this study were described.
Chapter Four: Findings

In this research study, I investigated the experiences of “expert” educators from a variety of specialties who teach non-English speaking patients. The participants’ experiences encompassed three components: factors affecting the experience, strategies for teaching non-English speaking patients, and outcomes of teaching non-English speaking patients. Those are the focus of this chapter.

Factors Affecting the Experience of the Educators

The participants identified a number of factors that affected the nature of their experience teaching non-English patients. These included the content to be taught and understood, the knowledge of the educator, the type of patient, and the available resources.

Nature of the Content

According to participants, one of the more difficult aspects of teaching in working with non-English speaking patients is the ability to communicate instructions and ideas to the patient and to be able to ascertain whether or the patient has understood. It was clear in the interviews that the nature of the content can affect this experience. For example, all participants agreed that if the content to be taught was a psychomotor skill, the complexity of teaching and evaluating learning was significantly less than if the content was in-depth theory, such as pathophysiology or concept related, such as behavioral change. Participants concurred that when an instructor’s task is to teach a psychomotor skill, repetition and a “copy-cat strategy” can be employed repeatedly with little verbal communication. They stated that return demonstration of a learned skill makes it is obvious whether or not the patient can
perform the skill, regardless of the primary language spoken. They indicated that body language and facial expressions are the key to its success.

All of the participants reported increased difficulty when teaching more abstract material versus teaching a specific psychomotor skill. The educators also concurred that despite the complexity, understanding key concepts is the most vital component for patient education, particularly in order for patients to adequately participate in their own care and decision-making about their disease management. Despite this, the participants agreed that no clear method that will convey vital concepts and ideas to non-English speaking patients seems to exist.

It's very difficult sometimes to get through to them [patients] with just the stuff I have here, how urgent some of these things are, and what a huge effect they can have on their future in terms of how long they might live and with what kind of quality of life. I wish there was something more I could do.

Knowledge about Teaching

Participants concurred that their knowledge of how to teach was integral the nature of their experience teaching non-English speaking patients. Although all of the participants had been registered nurses for more than 10 years and patient education is an activity that is expected of all nurses, only one participant had had any exposure to principles of teaching or of adult learning and that experience was recent. Participants explained that they were originally selected for their job as a result of having had significant experience in the area of specialty, not as a result of any teaching skills or previous experience in teaching. They perceived that the employers' expectations of the role as well as their own were that they would have no difficulty teaching what they knew in terms of skills and disease management. Some
participants admitted that they had never considered the idea of having to teach patients that were non-English speaking or had limited English proficiency until they encountered this reality as an educator. As one participant sated, “It didn’t really seem to be much of a problem until the numbers really increased and now there are more [non-English speaking patients] every day”.

Participants said that once they experienced difficulties in teaching non-English speaking patients and they began to inquire about strategies to address this need, they discovered that there were no courses or books on how to teach patients with limited English proficiency and little in the way of resources.

I just remember what I started I read, I went everywhere, to journals and books and texts to find out easier ways and ways to get... and there was nothing there. There’s nothing about teaching. There’s nothing that actually... I mean it [text book] gives you all the principles of Adult Ed and all that stuff but there’s nothing out there, you almost need to take teaching and we don’t have that.

They agreed that even more frustrating was the fact that they had to learn things by trial and error and there was no one to whom they could turn for help in this regard.

I can remember [when I was] beginning teaching I went from A-Z through the book... every little thing was covered I want you to know. However, I never did ask this one gentleman if he had a bathtub! You assume they have daily care and he nodded “yes” but when a home care nurse went out; he didn’t have a shower or bathtub - he had to walk way down the road to have that done. I had neglected that, I was so focused. Then you learn as you go along, what’s important, like we don’t have to start at Chapter 1. You know, maybe for most people, Chapter 4 is where we need to start. Then we can go back and do Chapter 1 later on and you kind of really do some of those things and I think you need to hear that from other people that it’s “OKAY” to do all these things and to figure out different ways.
Participants reported that they made some extraordinary efforts to meet the needs of their non-English speaking patients. “We did ask to have a little bit in a pre-admission interest group meeting where a social worker … just touched on a little bit, like the Chinese and some of their health beliefs”. The educators explained that they “took advantage of what little there was that came their way” in regard to how to teach non-English speaking patients because “anything is an improvement on what I have now”.

Knowledge about Other Cultures

Each of the participants mentioned that the information they possess about different cultures has a profound effect on the experience of teaching non-English speaking patients. A recurrent theme among the participants’ statements was their sense of inadequacy when it came to knowing about non-English speaking patients and their cultural norms. The educators often expressed concern about what they considered were errors that had occurred because of their ignorance. The following is a story told by one of the participants that illustrates that concern.

We did call for a professional interpreter to come to help us with the woman to prepare for surgery with no English, and it appeared that the husband’s English wasn’t all that good either when she tried to book the appointment so we decided we would err on side of caution…. It was a fairly significant surgery so I said, we’ll just get someone [an interpreter]. …we told them the name and what language we wanted, Punjabi … and the company sent this man out and there was an immediate … because we introduced them out here -- the patient to the interpreter -- and there was an immediate chill in the air and a very bad feeling going on. And this was a young woman who would not make eye contact. Head down. She, I had a feeling, had a lot more English comprehension than she was allowed to speak. Married to a much older man. And, I sensed this not good vibration between the man they sent and this man. And it was a very difficult interview, because I could tell that the husband was angry about this and he insisted on sitting in on the interview. So now we have the husband, the wife, the
professional interpreter and me. And, it was like pulling teeth. It was not good.
... So after they had gone, I talked to the interpreter about it and he said he knew right away there was a problem because of the caste system. He was from a different caste than the husband and he didn’t like it. He resented that interpreter. He said I would have been much better to have a woman interpreter come. I just didn’t know to ask.

Similar situations were reported by all participants; they stated that such situations left them feeling ineffective and occasionally even incompetent despite earnest attempts to meet the needs of the patients.

Some of the educators discussed their efforts at learning about culture and language and implied that they did not try hard enough nor do enough to meet the patient needs. This view was consistent even when they had gone to lengths beyond what is required by a job description. For example, some of the participants had taken some classes in other languages, one in Punjabi and one in Chinese but both still felt woefully inadequate. As one participant put it “there’s no way anybody could ever be fluent in all of the different languages anyway, so you’re going to be letting somebody down”. Some participants expressed the need to find access to information about general cultural issues and health beliefs. For example,

...the Chinese and some of their, you know, hot and cold and health beliefs and all of that which is huge. And they are quite superstitious or whatever you want to call that. Doesn’t matter. Those old Chinese people believe that and you have to work with it. You can’t expect them to just throw that away and do what you say. So, I think more education of front line people to know more about it. I know I would like to know that. I would like to know some of the ... like if there are culturally things ... just like this caste situation that I ran into with the interpreter.
The participants agreed that a sense of inadequacy related to lack of knowledge about culture can severely affect the interaction and trust between themselves and their patients and the ability to effectively communicate with them.

**Resources**

According to the participants, the type and availability of resources also had a significant effect on their experiences. The degree to which the educators perceived support for a program or a client group was dependant on the resources available. Those resources specifically discussed and considered essential by the participants are examined in the following sections.

**Literature.**

The participants found that existence and availability of literature or books on how to teach non-English speaking patients strategies or materials for teaching non-English speaking patients, is negligible. They found that even if a potentially helpful text could be identified, it was not likely to be available in the library and the cost would be prohibitive. The only information that some found centered on access to health care and was replete with examples of horrific outcomes related to inadequate communication and basic misunderstandings. The participants found despite an occasional article recognizing the growing dilemma of non-English speaking patients, few if any, authors offered solutions or strategies to deal with the complex problem. The participants in this study were not familiar with any educational approach recommended by any scholar or designated expert in the field of patient education or cultural competence to teach non-English speaking patients.
Continuing Education.

Several participants searched for courses or continuing education sessions to augment their skills teaching non-English speaking patients. They were unable to locate any that dealt with this issue. Participants commented that occasionally in their workplace or in the profession, a small workshop on a peripheral topic (i.e. Diversity in Religion) was offered or they might have the chance to take part in an informal presentation held by an interdisciplinary colleague on a particular patient's case. Participants agreed, although patient education was an expected area of competence for every nurse, it was not addressed specifically in any course, in-service, or professional update they had encountered. Additionally, they stated that the subject of non-English speaking patients was never identified as an issue in any nursing journals or professional forums of which they had knowledge.

Time.

Another of the resources repeatedly mentioned by the participants was time. All of the educators concurred that more time was essential to address the needs of the non-English speaking patient population than for those who spoke English. Many of the participants stated that the additional time needed to deal with communication and comprehension issues was a considered by some administrators, a strain on the health care system. They admitted that occasionally, they could “finagle extra time” for a non-English speaking patient but that generally, “it was just not possible” to provide the time required. One of the educators noted:

... it has to be simple. It has to be not, I don’t want to say the word quick, but you have a limited amount of time. So, often, it might be something that you could use to demonstrate and give to the patient
to take home and look at more. Because you can’t spend forever going through it. You just don’t have the luxury of more time.

This concept of more time for non-English speaking patients recurred throughout the interviews and was often a trigger for educators to remark that the nature of the job was not understood or appreciated by those in an administrative position. The only participant for whom time was not an issue stated that her administration was “completely behind her”, she schedules her own time, and if she feels that a patient needs additional time, she has “no difficulty making that happen”.

**Personnel.**

The participants regularly mentioned the possible use of additional personnel to improve the degree of communication with non-English speaking patients as another type of resource. The participants’ primary need generally centered on the use of paid professional interpreters. This particular approach is one of the most successful but certainly one of the most expensive resources in the health care system. Many of the participants spoke of the high cost of paid professional interpreters.

I know that translation is expensive and I know that at another hospital that I worked at we weren’t allowed to use interpreters because of the cost. ...here it’s built right in. It’s felt that it’s a good use of funds and that it’s important and how can you get the job done without it, right? So, it’s really made the teaching process, its facilitated it and its really been very helpful in the whole process. And I know that the patients are very grateful.

The later section on strategies addresses the subject of interpreters more fully, so at this point, I refer to the participants’ agreement that the lack of sufficient paid interpreters had a profound effect on the experience of educators with their non-English speaking patients. In addition, the participants agreed that providing this resource was a manifestation of the degree of commitment by an administration to
provide basic care to all patients without discrimination. Other personnel resources that the participants saw as beneficial include facilities and incentives for peer coaches, hiring of more ethnically diverse health care professionals, as well as additional regular staff to allow for increased time for non-English speaking patients.

Patient Characteristics

The participants stated that not only the patient’s ability to comprehend but also the patient’s perception of their ability to understand English had a profound effect on the overall experience. They noted that if a patient was able to competently answer demographic information and could verbalize a chief complaint, they assumed that he or she was able to adequately understand English. They indicated that often, the actual comprehension “fell frighteningly short of expectations”, and depending on the assessment resources and skills of the educator; the patient’s lack of understanding might not be discovered until an acute problem appeared.

According to the participants, the difference between the ways a patient perceives the health system (which may be colored by past events) and the way the educator sees it, also had an affect the nature of the experience.

We used to have Chinese nurse when I was working in the PD [peritoneal dialysis] Unit and we had a lovely Chinese lady come in. Fine, I figure I’ll let this Chinese nurse do the teaching and that will be great for her. One-day they’re chitchatting and they’re back and forth and they’re almost arguing and I finally said, “...what’s the problem here?” “Oh,” she said, “nothing.” Then a little later she came out and she said, “you’ll laugh at this ... because basically they [the patient and family] wanted to know when they’d be good enough to get the white nurse.” And, here I think I’m doing them the big favor to give them somebody who speaks in their own language and I was so proud of myself that I had taken care of this situation but they viewed me as sort of the boss and that they weren’t good enough to get the boss.
Further, this participant stated that because she thought she was doing “the best possible job” to meet the needs of her patient, she was surprised that the patient interpreted the experience as “not being good enough” to have the best.

Many of the educators in this study related that they saw patients’ health care beliefs as significant as that of language in interactions between themselves and non-English speaking patients. However, the patient’s health beliefs were not as readily visible or easy to ascertain as was his/her lack of English. The participants indicated that they were often not aware of divergent beliefs until a situation occurred in which the consequences of the divergence emerged. As one participant explained, “Up until that time, it just didn’t occur to me that others have a completely different way of looking at health and illness”. Another participant called such an experience “an awakening.”

I had a patient, a young Vietnamese man, who’s English was really pretty good. He had a good job with a big company and he traveled a lot. He was just diagnosed with [a chronic life threatening illness] and I spent several sessions explaining how his long history of hypertension had likely caused this problem and how he could avoid further damage etc., all the usual stuff. I got to know him a little and one day he told me he understood why he had this “sickness”. In his travels he had not been faithful to his wife, and this problem was the result of all of his dishonesty and worry. He said he had upset the balance in his life and in his body. He had listened politely to everything I told him, but he knew that until he had straightened out his life none of the things I told him mattered. It really made me think.

As seen in these last two examples, the unfamiliarity of the educators with foundational health beliefs of the non-English speaking patients and the their sense of not being “good enough” contributes not only to a sub optimal encounter but it also reinforces the notion of inadequacy and triggers additional self blame.
Strategies

The participants employed a variety of strategies to teach non-English speaking patients; they used some as a matter of necessity, some because of desperation, and others, because that was what had evolved or was done in the past. There were also strategies that evolved from the nature of the task and some that had yet to be implemented because they were only a series of ideas. The following are a collection of the strategies employed and envisioned by the participants in this study.

Translated Materials

Print.

Some of the educators reported limited access to handouts for patients; however, these were frequently not in the appropriate language for the patient. Participants reported that the material was often a mediocre translation of an older, not very effective English pamphlet that tended to be beyond any recommended reading level. Many of the educators had used a variety of translated print material from official handouts created by the hospital, clinic, or individual educator to handmade written translations by staff, family, or even the patients themselves. The participants expressed a need for improved translated materials, pamphlets, booklets, instructions, in a variety of different languages. They indicated that one of the most beneficial uses was the phrase sheet.

We give them ... bilingual sheets that give their word and then the English word for pain, nausea, I need to go to the bathroom, I want to talk to my family, major things if they have no English. I give them one in the clinic, tell them if they can read their own language, ...sometimes they’re illiterate in their own language but if they can read it then I tell them to take it home and study it and then I put one on their chart so that from the time they wake up after the surgery and in the recovery area they can access it and...
they’re at least familiar with it and can point to it …that written word, if they can read their own language is an extremely, wonderful thing to do.

The efficacy of translated print materials was frequently dependant on the quality of the pamphlet itself.

...my translated material is quite poor. It was a staff translation of a not very good English pamphlet. It uses a lot of medical terminology and really wasn’t very clear in the first place. The vocabulary was a high grade level and the explanation was quite advanced. We’re now working on that here at [name of hospital].

One participant shared that her institution was involved in a project to increase the number of Chinese language handouts for patients. Participants stated that, even when translated material was available often a more complex and multifaceted approach was needed to meet he needs of specific non-English speaking patients.

But his Chinese was an old Chinese. ...and there could have been question that this patient was not, didn’t have the education, as much... It could also be the possibility that he was a little slower. But I think it’s probably the education. You know, he came from a part of China where they didn’t have much, and so when he did write.... What I had to do with him, now, I had to actually get all the notes rewritten. He had to do it himself. So, it was kind of a longer process in the fact that we would use the main Chinese notes, but he would have to write it in his own hand. And write the steps, you know, every time ... what he was going do as we did them. yeah, it took a more work with him. However, he still had to learn all the alarms, air in blood or blood leak. He had to learn all the alarms he had to know what they meant and what to do.

Most of the participants agreed that more specific translated print material was a critical need for teaching non-English speaking patients. Many felt that if more information was available already translated that it might reduce the time required to teach these patients. One participant stated that an exception to generally poor-quality printed material is the Kidney Foundation of Canada manual Living with
Kidney Disease that is published in a number of languages. As one educator explained, “The patients come with it clutched in their hand. It’s their bible. It’s the only thing they have that they can even begin to figure out and I’m so grateful for it”.

Another educator did not believe increased use of print material was necessarily an advantage for the non-English speaking patient. She was the participant with most experience and with the most ethnically diverse patients and offered the following insight derived from her experience:

For quite a while we would provide a pamphlet in the language of choice for our refugee patients. It explained where the clinic was, what specific things we could assist with, and where we could refer patients for additional help. We seemed to give out hundreds of them. Then we ran out and couldn’t afford to reprint. No one seemed to notice, clients or staff. When we decided to paint the hallway and waiting room, we discovered tons of pamphlets stuffed in the back, some chewed up, probably from the toddlers playing with them. It made us wonder why. To make a long story short, we learned over time that many of these non-western cultures do not have a history of learning from printed material. They learn from family members, mothers, grandmothers, aunts, friends, etc. Their learning experience is an oral not written tradition. They seldom see the value or use of pamphlets.

Yet, another participant felt that it was not so much whether the material was in print or not, but whether the presentation was straightforward and simple.

I think that all teaching is difficult and I think, as we have people with chronic illness and a lot to deal with, the simpler we can make things, the better because I have... I know from my experience over the years that if you give them a book to read, very few are actually going to read that book. There is too much information and usually not enough pictures.

Many of the other educators stated that their experience had suggested to them that printed material would be helpful if they had it available. Nonetheless,
they were not aware of any evaluation of the use and efficacy of printed materials used to teaching no-English speaking patients.

**Audio-visual.**

Many participants mentioned using videotapes for instructional purposes, most often in English with a family member to translate for the patient. According to one participant, the value of audio visual in this regard is limited because “… we still have to get an interpreter to translate this four-minute video and explain what we are trying to tell them about a [visual] pain scale”. One educator did have some limited video material in both Chinese and Punjabi and would send the video home with the patient and his family. As to the efficacy of this approach, she stated that sometimes it was a useful aid and other times it could create questions that were more difficult to answer on subsequent appointments. Nonetheless, the participant reported that the patients seemed to appreciate having some information in their own language.

**Demonstration**

Some participants described a simple but effective approach to teaching a motor skill to a non-English speaking patient. They perform a demonstration of the skill to be mastered, and then have guided practice by the patient and finally a return demonstration by the patient to assess their performance. With this technique, the educator instructs an action and the patient repeats the skill until able to perform it at an acceptable level. The participants agreed that this technique is used with the least amount of verbalization and that they used non-verbal communication, body language
including facial expressions and gestures, to convey to patients the need to try again or the success of the attempt.

I demonstrate the whole thing at regular speed and then break it down into little bits and have the patient do a return demo of each bit adding a little more each time. I nod yes or smile when they get it right. It usually works fine even if they [patient] can’t speak English, just so long as they don’t have any questions or need to know “why”.

Participants reported that when they must convey concepts and theory or explain the “why” of a particular psychomotor skill, the experience of teaching non-English speaking patients becomes much more problematic. They stated that in such situations, both parties must be able to comprehend questions, perceptions, and ideas. All of the participants consider this approach most effective when teaching uncomplicated psychomotor skills and, that alone, it has little application in teaching health concepts and behavioral adaptations. When a more complex skill or a concept was taught most of the participants employed a combination of strategies.

Of course, you also use the family to translate what you’re teaching. If there’s something they can take home it great. Yeah, so that if they didn’t quite understand or get it, or if it was difficult or if they are doing it alone at home or something and they needed something to refer to, they’ve got it right there. And I think it really helps. Some people are visual learners and some are, you know, auditory. And so as many different techniques that you can bring in, I think, are really valuable. Because you use anything and everything that might help them get it.

**Visual Learning**

As indicated by the participants visually based learning has been used for both psychomotor skills and behavioral change (i.e. change in diet, smoking cessation, etc.). Most often this strategy is used in conjunction with an interpreter or with language specific text. The participants stated that it consists of a number
of techniques that use pictures, graphs, drawings, diagrams and models, as well as actual equipment as the primary method of instruction. According to the educators, demonstration (live or recorded) is a type of visual learning; however, they most often consider it a strategy in its own right. The technique they most often discussed as visual learning was using pictures in a sequence that depicted a desired behavior, an example of appropriate activity, a required task, or even a concept. Some of the participants used models and pictures to elucidate their points.

...sometimes we use the real thing. I show them the catheter with its cuffs and, yeah there are pictures too. I find those helpful, for the patients, particularly if they don't speak English. ... we do actually have a procedure that's just basically pictures, right. It works. And usually the family members will write on lots of stuff on there for their benefit if they feel like that might help them. We've got large posters that are in Chinese and ... it seems kind of big for people to use so we cut down the pictures and make them into booklets: when they complete a task, flip the page kind of thing. But pictures really help I wish there were more for all the things we teach.

In fact, the last patient I was telling you about -- that was quite a challenge -- with him it was a bit slow in the beginning because he just wasn't getting it... Like some are more tactile learners. They watch it a bit, they do it a few times, things are sinking in. But he wasn't. even hearing, he doesn't. I don't think he remembered as much, you know, some of them are better at that, and some aren't, but he had to have it all.... more, I guess a visual learner. And, if it was a part that he couldn't get ... I would use models, you know and pictures.

As explained by the participants, the keys to achieving the desired effect are simplicity and cultural appropriateness. For example, one participant described using a tea bag to depict movement of water in and out of a cell. She was used to the fact that this analogy had always provided understanding of the
concept (osmosis). On one particular occasion, it was clear that the patient had no idea what she was talking about and she [the educator] was quite surprised that the patient was so confused. Sometime later, she discovered through a colleague that this patient had lived in a rural area of Cambodia and although he drank lots of tea had never used a tea bag and therefore did not understand the analogy.

Interpreters

Interpretation was by far the most common strategy for teaching non-English speaking patients according to the participants. This strategy engendered the most discussion in the interviews. The participants reported a distinct learning curve for themselves when they first began using an interpreter, as they explained that they had never before encountered a professional situation that required translation. Once again, the expectation was that they already knew the proper procedure for using an interpreter and no information, in-service or directives were given to facilitate the practice. One educator shared: “I, at first, the first time I did it, it seemed a really awkward, right, and I would speak to the interpreter as opposed to actually to the patient”. Yet another participant agreed:

Sometimes, I find that I end up talking, and this makes me feel bad, I end up talking over the person, the patient. And it’s because you kind of ignore that person in a sense. And talk to who’s doing the interpreting.

The awkwardness and lack of knowledge about the correct way to incorporate the skills of an interpreter related by these educators reinforced the sense of frustration and inadequacy experienced by many of the participants. Many of the rest of the comments were specific to the type of interpreter used and are therefore presented in that manner as follows.
Ad Hoc Staff/Volunteers.

The participants stated that the use of ad hoc staff and hospital volunteers to translate was a common practice, particularly in unexpected or emergency situations. These volunteers were also used in place of professional interpreters to reduce financial considerations in several of the institutions.

...and it's interesting because here at [name of hospital] we have a just started a …Chinese speaking dietician. And since that time, I found out all kinds of things I would never know, because the dietician interprets for me.

Another participant recounted...

We do have some in-house volunteers and staff who have been trained. They are not professional interpreters, but they’re trained to do medical interpretation. And, I would have to hunt somebody down. Hopefully there would be somebody here. But again, you get into an issue, I guess I always felt that that might not be good confidentially, you know. But that maybe confidentiality might be somehow broken.

Participants voiced other concerns related to using staff for interpretation. These issues ranged from the practice of removing staff from their own job, to the fact that the time they have available is insufficient.

so I go to the telephone and I phone to Interpreter Services and if they don’t have someone right there then I would ask them to find a nurse. Somebody to come and help interpret for 20 minutes. They’re pulled off the ward so… so that’s not that good because ah… I mean they’ve got other jobs right and they can’t be ah… you know spending too long with us. So if that happens like where we… I mean the questions are asked fast and furiously and then if the dietician or the doctor wants to come – right? Then… we’re really in trouble so…

One of the participants also expressed a concern that if the patient was a member of an uncommon ethnic group, it was likely that the volunteer or staff member might know the patient in a social context and fear of disclosure of a
personal or sensitive issue, as well as confidentiality, could become a serious issue. The findings showed that although the participants stated they were pleased to have translation assistance when they needed it, most of them felt that the current system for meeting interpretation needs was inadequate.

**Family/Friend Interpreter.**

All of the participants agreed that the position of interpreter was most often applied to a friend or family member. “The majority of the people we see with English as a second language, we use a family member simply because of all the issues around the cost of getting someone in and never being quite sure how good the English really is.” One of the participants pointed out that in a brochure for her clinic it stated in the “tips for patients” section, to remember to bring “some who could speak English”. Despite this overwhelmingly widespread use of family and friends for interpretation, each of the participants had serious concerns about this practice, such as issues relating to confidentiality and the interpreter’s ability to convey the content as the educator desired.

…it can be kind of confusing if they [family members] are the ones who do the interpreting. I don’t think the family members feel as free to speak their mind about certain things and I know that at one point I could not get any information about bowels at all, right. And it was just something that they didn’t speak of in front of all their family members. And so I’m sure that there are other private issues that people may not want to bring up if their whole family is there.

I found sometimes that some of the interpreters that I did have, especially if it was a family member, would edit what the patient would say. So, I would ask a question and there would be a lot of discussion and conversation and then I would get a yes or a no answer kind of thing, right? And I would find that really, really frustrating. You know I really wanted to know what all that other stuff was. And so I also found that because of that I didn’t often
get sometimes all of the information. I got information that was partial or sometimes because of that I missed information and had to sometimes guess. And/or I didn’t exactly know what questions to ask in order to make sure that I got all of the answers. I think the biggest thing is that they filter the information. I don’t feel I get the straight goods sometimes with family members. And, I also feel that they don’t exactly know how to interpret properly.

One participant shared a concern about not knowing what is being said in prolonged conversations between the patient and his/her family member or friend. She stated that she fears she is “missing some vital information” or that the interpreter is explaining something incorrectly.

I’ll ask a question “like how are you?” There will be this long conversation with their family member like, you know, three minutes long and they’ll turn to me and say “Good – Fine” and you think “What were they saying – what was that all about?” And you don’t want to set it up by saying “Now come on – that was three minute worth to say that?”

In an effort to limit the amount of extraneous conversation and increase the amount of material actually being presented to the patient by the family or friend interpreter, one of the participants developed a unique approach to explaining in a clear and understandable manner what her expectations of the interpreter were. The following comment illustrates the kind of creativity that emerges from necessity and repeated encounters.

You’re my telephone – I will ask you the questions and regardless of whether you know that question or not I want you to ask your mother or whoever and give me the answer back that she tells you. Even if you know the answer don’t say it, just be the phone and tell what SHE says … You have to keep reminding them of that but at least you hope because you know they communicated that, that it has come back from the patient and not from the family member.

According to the findings of this study, the issues of using family and friends as interpreters, centered on the difficulty in trying to determine how effective the
teaching was in providing the most critical information to the patient. The participants agreed that when interviewing the patient through a family or friend interpreter, it was difficult to ascertain if the answer came from the patient or the helper. One participant summed it up this way. “You know, somebody’s [interpreting] whose language skills aren’t good but they really want to help and sometimes it they say everything is ok and it’s clear it’s not... yeah, it’s really tough for all of us, I think.”

Professional Interpreters.

All participants remarked that they appreciated professional interpreters the most. They concurred that not only was it easier to provide information to and ask questions of the non-English speaking participants with a professional interpreter, but they were more able to assess the effectiveness of their teaching. One participant offered a comparison of an interview with and without a professional interpreter:

Two experiences, back to back, who just sort of exemplified, you know, some of the issues around people without English -- in the health care field, of course. My 10:00 a.m. appointment was with an elderly, well not that old; I think he was around 62 or so, Punjabi gentlemen in his turban and traditional dress who came preparing for surgery with no English. None. And his son, who had a crew cut and was dressed in western clothes, who was going to be the interpreter for his dad. I thought I was going to have a problem with the son, because he seemed a little bit resistant. I said, “Even if you know the answer, I’d really like your dad to be the one.” And I thought he was resisting me. But what it evolved to be was the fact that I think the father and son’s relationship wasn’t great and this old man was not going to answer these questions for his son. He wasn’t going to tell him very much and then the son was getting really exasperated with the father and the father was just turning his head looking the other way! Not easy to teach in this situation.
My next appointment was with two young Punjabi-speaking brothers in their early twenties. We knew they had no English and had arranged for a professional interpreter to come, who came, and it was wonderful because he really expedited all the teaching. The patients got all the right information and I assessed what they needed and what they understood. He was such a wonderful help.

There was unanimity among the participants that the strategy of using a professional interpreter allowed the most efficient presentation and evaluation of the teaching sessions. The participants stated that it also provided the best assessment of the participants' comprehension of the material and permitted the clarification of questions that the patients were able to ask through the interpreter. On the other hand, the use of professional interpreters is not without its own set of difficulties. Participants agreed that establishing some degree of rapport is much more problematic and the interpreter may not be familiar with specific dialects of the patients. Although a considerable improvement, and a reasonably effective strategy, the use of professional interpreters is not a panacea.

Remote Translation.

Another method of interpretation that some participants identified was remote translation. Most of the participants were aware that it existed but agreed that they did not use it. Although some institutions subscribe to this service, none of the participants had very much experience with the service and were reluctant to comment on its use or efficacy.

Clearly the issue of communication and the best choice of interpreter for any given situation is a complex one. The many factors which must be taken into consideration range from the obvious (availability) to the less straightforward
(cultural ramifications). Nonetheless, according to the participants, it is the need for comprehension and assessment of that comprehension along with patient comfort that should drive the consideration of when and whom to use as an interpreter.

Peer Teaching

In general, the participants primarily relied on themselves as sole providers of information and guidance about the health issue in question. However, the accounts of several of the participants included some reference to educators using other patients in a secondary role to help teach both skills and concepts.

But I have to say with him, too, I knew he was struggling and it was hard for him and others were learning at a much faster rate. And actually, one of the other Chinese patients that used to go.... on the same shift.....when she’d get done really fast, then she would sit across the room and watch him and she would instruct him every time he made mistakes! So she’d..... I learned the word “Chinese teacher” for her, so we’d say, “Mrs. X is now the teacher, so she’ll watch everybody in the room.” So, you know, we did things like that. Whatever worked for the patient.

As in this example, other participants expressed their belief that, if well monitored the use of peer teaching could be an advantage in specific circumstances.

It’s [peer teaching] mainly utilized in pre-dialysis. You know, as an adjunct to getting them started and going. They have patients who been on treatment for sometime explain what it’s like and how it affected them and why they chose what they did for treatment. I’ve heard it works OK if the educator monitors everything.

You know, years ago we used to have a weekly meeting of new moms and we discovered that a huge amount of information was passed along in these sessions. As it turns out these non-English speaking patients, mostly refugees from third world countries, learn best from their elders and peers. They have a tradition of oral learning. They are more likely to trust the information they get from other women like themselves who have experienced the same things.
Despite these illustrations, and use of peer teaching in particular situations
the participants did express a number of concerns around this strategy.

You have to be careful about different classes of people. Because
you know, and I did see this in [teaching] Unit when one of the
doctors said, “well, just have Patient A teach Patient B. Should be
no problem – they speak the same language.” But they were
clearly from different cast systems. And clearly to anyone even
without speaking their language you could tell that that wasn’t
going well at all. And I wasn’t sure how to make it better.

You know it [peer teaching] works great if you’ve got the right
person but not every patient is right for the job. Like if they get
some big ego trip, or if they take to many short cuts, you know, it
can really be a big problem. Maybe more than it’s worth, if you’re
not careful.

Even though each participants’ practice employed a variety of strategies to
teach non-English speaking patients the fact that they had little or no training in the
use of these strategies and were forced to rely on trial and error to hone their craft left
the many participants feeling deficient in some way.

Outcomes

One of the recurring issues for the participants in this study was the sense that
they lacked the ability to determine with any certainty how effective their efforts were
in meeting what they perceived to be the needs of the non-English speaking patients.
For some participants outcomes were not the focus of their job, they provided
information to the best of their ability and hoped for the best. The only method for
evaluating effectiveness for these particular participants was to be aware of the
number of complaints about the patients’ behavior. In examining the participants’
accounts of the outcomes associated with their encounters with non-English speaking
patients it became evident that they saw the outcome of each encounter as evidence of
their ability or inability to teach this population. However, in addition to exploring this explicit aspect of outcome, I will examine what I consider to be another type of outcome, a personal outcome related to the participants’ comments about their sessions with non-English speaking patients that convey their personal sense of inadequacy and frustration with the ongoing task of teaching non-English speaking patients.

Teaching Outcomes

According to the educators in this study the assessment of teaching outcomes for non-English speaking patients was as difficult and complex as teaching this group and for many of the same reasons. The participants voiced many similar concerns relating to difficulty in determining the patients’ degree of comprehension and knowledge as they had for presenting material to non-English speaking patients. There was consensus among the participants that no adequate method existed in teaching non-English speaking to evaluate the degree of comprehension with regard to the educational objectives of individual programs. A sole exception was the ability to perform a simple skill, as previously discussed.

Frequently, according to the participants, patients would indicate either through body language (nodding and smiling) or via an interpreter, that they understood the subject being taught. However, the educators stated that on numerous occasions, they felt that the patients were merely being polite, or that perhaps they did not want to upset someone who was helping them or a person who they perceived could influence their care or course of treatment.

I find that the patients are often very polite and acknowledge yes, they understand, when the reality is they might not. I do try to
confirm that they’ve got the answer, right, by making sure that they sat it back to me. But yeah, there are many times when I’m not quite sure.

Sometimes we forget that some of the patients are really kind of scared. They might not’ve ever been in a hospital or with medical type people. Lots of times they don’t even know what’s wrong with them, only that it’s not good. The last thing they’re gonna do is something that might tick you off, like say they don’t understand you. Or maybe it’s because they think you might treat them like they’re stupid then.

Some of the participants said that they only recognized a lack of understanding by their non-English speaking patients when on a later occasion, they discovered that the hospital staff described these patients as non-compliant.

They [non-English speaking patient] just didn’t understand the reason. They are told to do a certain thing. They are told do this, do that. And because they don’t really understand the rationale behind it, they may not actually comply. But if they understood the reason for taking their TUMS© with their food, kind of thing, they would do it, right. Because they knew it would protect their bones kind of thing.

The study findings illustrated that a better method of assessment and communication is critical to providing equal and adequate care to the non-English speaking patient population.

Personal Outcomes

The personal outcomes that participants identified related primarily to the frustration and sense of inadequacy they felt as a result not being able to perform their job in a manner that met their personal and professional standards. When discussing what they reported as inadequate methods or tools to properly assess the patients’ understanding of crucial material, the participants frequently expressed frustration.
The first thing I want to make sure is that they know how to do the procedure. But for all the other things, they are kind of subjective sorts of things, right, that I need their feedback. I can't actually assess. I can't see what I need to know. It's really hard and I still don't have a good way to do it.

I wouldn't know that, if I don't have someone good translating for me. It would be pretty ... it would be not complete. Not an accurate assessment without that information. And I would have concerns around their safety at home. They might not be safe without a good evaluation. They would be in the hospital with infections, and ... I mean if they are infected then you know there is a problem. It's a bad way to find that out and not really fair for the patient.

The educators in this study also spoke frequently of blame when the non-English patients did not understand what had been taught; both self directed blame and blame from other colleagues.

...we're preparing them for surgery, we're telling them how they get ready, when to stop eating, when to stop drinking, what medicine they should take the morning of the surgery, what not to take. And believe me you'll be first one to hear if they don't come at the right time or they didn't fast at the proper time or take the right medicine. It's your fault, sort of, and you feel like you blew it.

Our education of non-English speaking patients is, I don't think it's as good that of our English-speaking patients. No. And I think some of it is just from a timeframe – I do not have time – (sigh) it's a huge time and again I'm not sure am I getting my message across. I don't feel like I'm doing the best job I could.

Yet another participant when speaking of her intention to improve her ability to teach non-English speaking patients by taking languages classes completed her statement by offhandedly attributing her inaction to date as lack of dedication.

You know, I keep saying that I'm going to learn to speak Chinese or Hindi or something. I learned a few words in each, just to be able to say something. But you know, I never get around to doing it. Just not dedicated enough I guess, eh?
Even though the focus of most of the discourse with the participants was primarily about the difficulties associated with the barriers to education of non-English speaking patients, occasionally the participants spoke of an enormous sense of satisfaction when they were able to meet the needs of a non-English speaking patient. They stated that sometimes, with hard work, perseverance, and the right combination of resources, at the right time, they were able to provide an individual patient with the information and assistance they needed to make a decision or to understand an important issue about their health. It was at these times that they experienced personal satisfaction as educators.

So with that one patient I did everything I could, I used all my tricks. I would give him homework cause he would have to write - say the alarm -- and write it in his language and would have to understand it. And this we did through interpreters. So, you know, that way ... also through the text or certain nurses. When I had them I would also get some of the Chinese nurses assigned with me in the room so they could help with some of the teaching. ...So it would be in small amounts each time. But there was a lot of review that I had to do with him. ...And I would have him go over it and then come back and we’d have to test him to see if he understood it and he would have to tell us [participant and interpreter] what it was. And I made little signs in English like “air in blood” say, for example, that would be one of the alarms. And I would hold it up and he would read it, and he would have to tell me what it is, or through an interpreter say what it is. But a lot of times he had trouble, after a while, he could read it, “air in blood”. He knew what it was. And he knew colours, you know, so I could use things like that. So, yeah, it worked many different ways. Finally he got it! He actually signed himself into English class too, because I think he was realizing that he could do more.

This example demonstrates that the achievement of a successful outcome encourages the educators to persevere in their endeavors to provide services to this group of patients, despite the difficulties they encounter.
Summary of Findings

Throughout this chapter I presented the findings of this study. I considered the comments and stories of the participants and the issues that emerged from their discourse. I used their words to illustrate the commonality of their experiences and highlight the similarity of ways of thinking and responding to the problems that arose within the context of trying to educate non-English speaking patients about their health issues. These findings raise some concerns about the practice of patient education that relate to the ability to include non-English speaking patients in this aspect of patient care as well as the ability to prepare and support nurses to competently perform this task. I will explore these and other issues in Chapter Five.
Chapter Five

In the analysis of the research data, commonality of the participants' experiences and the similarity of the ways of thinking about and responding to problems, led to my questioning how the participants envisioned patient education and in particular, how they viewed education of non-English speaking patients. Instead of considering only what barriers language presented to the educators, perhaps, I needed to look a bit further. I wondered, "What did patient education mean to them?" and "How did their view of patient education for non-English speaking patients come about." I looked at what factors determined their perception of the process and how this view of education for non-English speaking patients contributed to the patient-educator encounter and the subsequent outcomes. The picture of teaching non-English speaking patients that I assembled from the participants' data includes several characteristics that are discussed further throughout this chapter.

Educators' Perceptions of Teaching non-English Speaking Patients

In conducting and analyzing the data from the interviews I noted a tendency of the participants to look at the non-English speaking patients (actually, all patients) as receptacles for information, albeit important information, that the educators felt they needed. This approach is not unusual in health and medical areas it relates to patient knowledge of condition, prognosis and treatment (Redman, 1997; Roter, Stashefshy-Margalit, et al., 2001). It is sometimes referred to as the empty vessel theory of teaching; i.e., the idea that the teaching consists solely of providing information that the patient/student is lacking (Springhouse Corporation, 1987; Babcock & Miller, 1994; Close, 1998). This view also conforms to a picture of non-
English patient education as content driven. As the data revealed, participants frequently felt that a physician-based agenda or appointment directed the subject of the session rather than any real or perceived patient need. Accordingly, the needs of the patient, as understood by the patient, are not addressed; it is what the physician or nurse believes the patient should know that is paramount in this approach.

Another characteristic of the educators' view is that teaching non-English speaking patients is, more often than not, frustrating and frequently inadequate to meet the patient's needs. One characteristic of the educators' view of the process of teaching non-English speaking patients that appears to arise directly from perceived institutional needs and lack of supportive infrastructure is, that the education of non-English speaking patients is an adjunct or add-on service in health care. In other words, this type of education is non-essential. The educators also viewed teaching non-English speaking patients as time-restricted. This stems from the educators' experience that additional time is seldom available to deal with the formidable barriers that lack of linguistic comprehension presents, regardless of the importance of the issue for patients' participation in care and decision-making. Finally, the educators addressed teaching non-English speaking patients as a function of nursing, not of teaching.

In summary, the characteristics of this perception of the process of teaching non-English speaking patients as seen by the participants are numerous. They include the idea of education as "filling an empty vessel" transfer of expert (the nurse) knowledge to ignorant vessel (the student). The process was also viewed as restricted by time, and, for a variety of reasons, frustrating. Two principal characteristics that I
feel were linked are that the process was content driven and educator focused (not dependent on patients' perceived needs). Other notions that contributed to this view were that the agenda was frequently initiated by the institution rather than the educator or patient, in other words for the convenience of health care professionals or institutional schedules. The participants also perceived the teaching of non-English speaking patients to be a non-essential service as it could apparently be eliminated during times of fiscal restraint. Finally, but perhaps, most importantly, the process of education for non-English speaking patients is seen as an extension of the function of nursing, not as teaching. These characteristics covered in more detail later in the chapter.

Gaps in the Literature

In looking to the literature for comparisons to other constructs of patient education for non-English speaking patients, I discovered that the paucity of research and literature on this subject remains a stumbling block. Despite searches in many databases, PsychINFO, EBSACO, WebSPIRS, MAS Ultra, Canadian MAS Elite, and the Academic Search Elite and others, I was unable to locate any material that would allow a comparison of this view of education for non-English speaking persons. What data there were, related more often to how to deal with teaching English as a second language, rather than teaching specific skills and concepts relating to (health) behavior change. Often in the literature of other fields, the discourse tends to be focused primarily on English as a second language or it focuses solely on culture and ignores issues of communication and comprehension (Wertsch, 1985; Nicke,l 1990; Cervero & Wilson, 1999; Terry, 2001). While in patient education, the focus tends to
be on more complex and often conceptual issues, such as how to behave in a manner that delays a disease process or why changes in previously benign activities are warranted. This inherent difference, along with the lack of research in this genre, makes comparison and potential conclusions difficult, if not impossible.

This research study does provide some relevance within the area of interpretation as it relates to communication between health care professionals and non-English speaking patients. The researchers in several studies agreed that accuracy, accessibility, and respect for confidentiality were highly important characteristics of interpreter services (Manson, 1988; Todd, Samaroo, et al., 1993; Baker, Parker, et al., 1996; Hornberger, Gibson, et al., 1996; Zahn, Clutterbuck, et al., 1998; Carrasguillo, Orav, et al., 1999; Kuo & Fagan 1999). In one publication, (Singh, Lele, et al., 1997) the obstacles of researching via interpreters and translators was addressed and issues of miscommunication discussed. Therefore, although there is some literature on particular aspects of communication with non-English speaking patients or clients, there remains little or no data on teaching those with little or no English, especially in an urgent or life altering situation. The result of this lack of data is that other than to position this study as initial inquiry into the education of non-English speaking patients, I am unable to situate it within the context of other relevant publications. On the other hand, this study does reiterate the concerns associated with the difficulties encountered by ethnic minorities when trying to gain access to health care and the problems associated with language barriers in health care in general. However, this study explores the issue from the vantage point of the
health care professional (nurse educator, in this case) as opposed to the individuals seeking help or information.

**Contextual Factors Influencing the Educators**

As highlighted by the findings, one factor that was likely a contributor to the educators’ view of the process of patient education for non-English speaking patients was their lack of knowledge and understanding about different cultures within the population of non-English speaking patients. In many instances, the participants’ ignorance in this regard effectively eliminated the possibility of real communication and mutual understanding between the educator and patient or family. According to a number of authors, without educators understanding the context of an individual’s health belief, their attempts to change the person’s health behavior is often fruitless (Anderson, 1996; Ferran, Tracy, et al., 1999). Indeed, this was the experience of the participants, who despite a variety of strategies, often felt that true communication and exchange of ideas between themselves and non-English speaking patients never materialized. What they, as novices in teaching non-English speaking patients initially considered to be simply a need for language support (i.e., an interpreter or translated publications), they later realized, with more experience, to be inexorably linked to the patients’ traditions, health beliefs, and culture. Although this change in approach has not, to my knowledge, been previously documented in the arena of patient education, it has been noted extensively in literature associated with access to health care by ethnically diverse populations and in texts and articles relating to cultural competency (Mensah, 1989; Tripp-Reimer & Afifi, 1989; Spector, 1996; Galanti, 1997; Waldman, 1998; Riddick, 1999).
Lack of training in the skills of teaching and the principles of adult learning are other factors that, I believe, have contributed to the way in which educators have constructed patient education. Although not discussed in detail by the participants, the demographic data and subsequent informal conversations confirmed that with one exception, the participants did not have any formal education or training in the principles of adult learning or theories of education. This deficit is compounded by an already difficult situation (that of patients who speak a different language) superimposed on another problem (the lack of foundational teaching concepts such as situated learning, relevance of subject matter to learner, building on existing knowledge and experience, and readiness to learn). This places the educators in particularly untenable circumstances and contributes to their rather limited and pessimistic view of teaching non-English speaking patients. The benefit of understanding theories of adult learning by such authorities as Freire, Foucault, Piaget, Lindeman, Vygotsky, and others, in addition to providing a foundation for teaching all patients, would be to expand the educator’s ability to select appropriate strategies for teaching non-English speaking patients. For example, adult learning strategies such as linking known to unknown, providing motivation for learning, scaffolding, establishing relevance, and acknowledging each patient’s experience would allow the educators to better understand the patients’ issues that affect their learning. It may have been in previous times that educators were able to survive without this knowledge but when faced with the enormous communication problems of this population the rising immigration to Canada, and increased patient acuity, educators must confront the inadequacy of past practices.
Another influencing factor for this common view of education for non-English speaking patients arises from the history of patient education in nursing; patient education has evolved as an extension of the nurse’s role to meet patient needs. This was evident throughout the interviews despite not being directly commented upon by the participants. In early years of patient education literature, nurses were seen to provide patients with information they were lacking and patients were portrayed as passive recipients (Redman, 1997). This remains a common viewpoint as stated in nursing diagnoses such as “Knowledge Deficit” (North American Nursing Diagnosis Association, 1994) in which the patient is seen as missing vital information that the nurse “gives” to the patient. This traditional approach to patient education fosters a tendency to ignore patient-focused questions such as “What does the patient think they need to know, and “What does the patient want to know?” In fact, with the interview and focus group alike the emphasis was on how to get the information to the patient, seldom if ever on what the patient might want to know. Learning is a great deal more complex that such a perspective would imply and the role of active learning as integral to the retention to new learning seems not to have received much attention in the practice or literature to date.

The model of the omniscient teacher is reinforced by the traditional biomedical model of health care and the idea that health care professionals are “experts” not only in the disease process but in knowing what it is patients need to know (Babcock & Miller, 1994; Redman, 1997). The authority of the educator in teaching non-English speaking patients is also strengthened by the fact that patient educators teach from whom they are as nurses rather than whom they are as teachers.
The nurse educators' primary goal is to assist patients in improving their state of health to a point the nurse sees as acceptable. The onus and therefore the focus of any teaching encounter by nurses is for the nurse to provide the information the patient needs to be as healthy as possible. This creates a teacher-focused encounter and the nurse’s main concerns during teaching are, “How can I get this information across?” “How can I tell if the patient understands what I think they need to know?” For all but one of the participants, these questions were their primary concern and related to the very real issue of “How am I to do my job well under these circumstances (i.e., with a language barrier)?” The potentially tragic consequences that can emerge from nurses’ ostensibly beneficent view of themselves as experts who instill knowledge into patients are skillfully and compassionately illustrated in the exceptional book The Spirit Catches You and You Fall Down (Fadiman, 1997). In this story, well-meaning health care professionals contrived to see a child’s illness from their own “expert” perspective and failed to assess the family’s level of understanding of what was occurring and what meaning it had to them. Consequently, unintended and unfortunate results occurred.

Other less visible factors also appear to contribute to the participants’ view of the process of teaching non-English speaking patients. Among them is the virtual isolation of patient educators. Again, although there were few comments in the interviews or focus group directly relating to isolation, the fact of not having the benefit peers to interact with was obvious during the informal meeting of participants. The educators were eager to commiserate and swap stories about what they perceived to be unique problems only to learn that their experiences were remarkably similar to
each other. This illustrated to me the profound isolation that each participant had experienced. Most patient educators tend to work alone due to their small numbers and the nature of the task. They seldom have the opportunity to share experiences, strategies, or stories with colleagues who perform the same or similar work. Lack of community and inability to share what they had learned over time or to discover what others had done placed these educators at a distinct disadvantage in teaching non-English speaking patients.

In addition to the factors mentioned above, another factor that added to this view and was reiterated in many ways by the participants was a perceived lack of administrative support. An infrastructure that had the potential to provide a foundation to enable more effective programs for non-English speaking patients was not apparent to the participants. For example, the findings of this study suggested that educators, for the most part, limited the use of professional interpreters to the most obvious and dire cases in order to decrease institutional costs. These educators also felt that they were unable to take the necessary time that was required to improve understanding and address the unique needs of the non-English speaking. This lack of sufficient time occurred because of scheduling concerns such as appointments with other health care professionals or only having a single appointment to cover all pertinent material or sometimes as a result of a patients' physical or emotional condition.

In several reports of studies on the effectiveness of patient education, the authors show that sufficient time to teach non-English speaking patients results in their ability to accurately comprehend the material being presented and improves
their adherence to prescribed regimes, as well as their health outcomes (Manson, 1988; Brus, 1997; Long, 1998). Two authors (Anderson, 1990; Marin, Burhansstipanov, et al., 1995), who reported on the needs of non-English speaking patients illustrated that greater time needs to be spent with non-English speaking patients to allow for the accurate exchange of information and assessment of comprehension.

Other infrastructure limitations noted by the participants were the lack of educational in-services and continuing education for nurse educators on issues related to teaching non-English speaking patients. The consequences of the lack of education about their role and about teaching non-English speaking patients were that the participants often did not recognize problems in a patient's comprehension until after the fact. In addition, they were not required by administration of the institution to be well-versed in instructional techniques or educational theory and therefore, were not. The absence of workshops, inservices, or other advanced practice learning opportunities for patient educators points to the lack of attention that patient education is given as a priority for health care.

Other constraints noted by the participants of the study, such as institutional and departmental needs, add to the factors that influence the construction of patient education of non-English speaking patients. Within the findings of this study, several participants reported that when staff were used as interpreters in ad hoc situations or even in planned encounters, the time allowed was rarely sufficient or the educator felt guilty that the staff member was removed from their primary responsibility in order to help them. Thus, the nurse educator tried to limit the time of the interaction. This
practice of having to resort to a haphazard, "luck of the draw" system of translation with indeterminate periods of activity reinforces the non-essential nature of patient education. As evidenced by the findings, the amount of time for patients to be seen was often not dictated by the patient or the educator but by a physician’s or surgeon’s needs and sometimes even by an operating room slate. As the needs of physicians and the operating room are often time-limited, this creates an underlying message that patient education can occur in short, concentrated sessions where an educator speaks and the patient listens, ostensibly absorbing knowledge. The pervasiveness of the practice of insisting on an educational session despite the reality of the patient’s condition and according to an arbitrary schedule, reinforces the idea that this practice is effective in meeting patients’ needs for learning despite evidence to the contrary.

Another factor ostensibly helped to shape the participants’ construction of teaching non-English speaking patients was the effect of their past negative experiences. Each occasion that an educator’s encounter with a non-English speaking patient led to a less than successful outcome, regardless of the reasons, contributed to the participants’ construction of teaching non-English speaking patients as hopeless and negative.

Schematic Representation of the Challenge of Patient Education with a Linguistic Barrier

The analytic framework as originally constructed suggested the likelihood of several of the research findings. Among them was the importance of a supportive administration, the need for an adequate infrastructure including language services,
and the significance of strategies and tools specific to teaching non-English speaking patients. However, rather than being solely about the barriers of language, the research data revealed that the process of teaching non-English speaking patients has been viewed by nurse educators as a largely negative and discouraging situation over which they had little influence. Examining factors that influenced this view provided an explanation of the outcomes and placed them in a contextual arena. This evolved into a schematic diagram that more clearly linked the findings to the proposed educators' view of teaching non-English speaking patients. It also illustrates the factors as they relate to the proposed view of the process of teaching non-English speaking patients and the associated outcomes as I interpreted them (see figure 2).

The differences between the original analytic framework and the schematic representation are primarily that the former was developed from appropriate literature as a guide for the study and took a broad view of the encounter between the non-English speaking patients and the nurse educators. It proposed potential categories that might be expected. The latter, a schematic representation, focuses more specifically on the process of teaching non-English speaking patients, the effect of certain factors on the nurse educators and their personal outcomes. It also examines how these, in turn, contributed to the discomfort in teaching non-English speaking patients and the struggle for the educators to find avenues for increasing their knowledge of diverse cultures and health beliefs and to improve their understanding of the basic principles of adult learning.
Schematic Representation of the Challenge of Linguistic Barriers

Participants' Perception of teaching non-English Speaking Patients as
- Time-Restricted
- Content-driven
- Filling an Empty Vessel
- Frustrating Task
- Non-essential
- Nursing not Teaching
- Devalued Role
- Teacher-focused

Previous Analytic Framework

Factors Influencing Construction
- Understanding of Culture
- Understanding of Teaching
- Previous Experience (pt/nurse)
- Lack of Administrative Support
- Isolation, Lack of Community
- Hierarchy of Needs (institutional > patient)

Outcomes
- ↓ Patient learning
- Self-Blame
- Frustration
- ↓ Patient self care
- Possible ↓'d improvement in patient health status

Effect on Nurse Educators
- Discomfort teaching this group of patients
- Struggle to ↑'knowledge of different cultures and teaching/learning
This perspective of teaching non-English speaking patients by nurse educators allows a focus of questions such as, What outcomes are associated with an educator’s view of teaching non-English speaking patients? The participants reported not only the typical evaluative learning outcomes but also very personal outcomes from their encounters with the patients. It is the personal outcomes that this view of the process of teaching non-English speaking patients helps us to place in perspective. For example, the emergence of questions surrounding patients’ ongoing health (“Did they understand the message or will they get infections?”) and negative learning outcomes (“I’ll have to call him back and try something else”) can be placed in the context of time restrictions and the idea that educators perceive this is an extension of nursing, rather than an application of knowledge about teaching and learning. In addition, the educators’ self-blame (“I should have found a way to do it”) and negative identity (“I guess I’m not dedicated enough eh?”) are understandable outcomes that can result from a perception of not being valued and a feeling of inadequacy, stemming from lack of knowledge. Together these outcomes contribute to participants’ concerns about their competency and teaching ability. Finally, they create a continuous struggle for nurse educators to know more not only about principles of learning and what strategies to employ in order to teach non-English speaking patients, but what are culturally significant and relevant teaching practices that affect the communication with each patient.

Although there are a variety of andragogical theories on which one might base a vision of a particular type of teaching, it appears that no expert has developed a theoretical concept of patient education for this population. Although there are many
experts to whom I could turn for inspiration to develop a more optimistic view of education for non-English speaking patients, contributions from external experts would belie the experiences of these patient educators in the field. Rather, what is needed is a comprehensive examination of the factors that influence the process and outcome of patient education for non-English speaking patients and a commitment to minimizing the barriers that language represents. There are, however, a set of common principles of adult education that would, in part, provide a basis for the education for non-English speaking patients. Hopefully, changes in the precipitating factors will create a less discouraging view of education for these patients. It is important to keep in mind that despite the commonality of the findings, this research remains an introductory study of this area of patient care and, as is typical of qualitative studies, employs a small study sample. Therefore, although this discussion may provide insight for others in the field of education for non-English speaking patients, and a foundation for changes in current practice and administration relating to non-English speaking patients; it does not present a definitive solution to the linguistic barriers to the education of non-English speaking patients.
Chapter Six: Summary Conclusions and Recommendations

Summary

The purpose of this study was to investigate the experiences of nurse educators who are confronted with the task of teaching health care to non-English speaking patients. I arrived at this goal in my previous experience as a patient educator in a renal program. When I was suddenly faced with a growing number of ethnically diverse patients that spoke little or no English, I was concerned that I was unable to find any useful information or tools to support my practice in this area. This incident caused me to consider the practice of others in the field to determine what experiences they had encountered with non-English speaking patients and what were doing to meet the needs of this very diverse group of patients.

In the research that has been described in preceding chapters, I chose to use interpretive description as the research method for this investigation; it allowed me to examine the data from a nursing practice perspective and to interpret the individuals’ experience to demonstrate the possibility of shared realities. Six nurse educators, who were recommended by supervisors, participated in the study. Each shared their stories with me in an initial interview. The earliest interviews drew primarily on individual experiences as presented by the participants. In the course of the research, I received direction from the participants and began to focus the interview more on the factors that influenced the experiences of the educators. Subsequently, the participants discussed the research findings in a focus group; their responses to these data contributed validation and an enhanced understanding of the subject. In general, the findings of this study illustrate that nurse educator participants felt that non-
English speaking patients were not receiving the same care from them, as were
English speaking patients. They felt the reasons for this were multifactoral,
encompassing their own skills as educators, the preparation and support they received
for teaching non-English speaking people, their degree of knowledge about other
cultures, and the previous experiences of the patients in question. There was clearly a
sense of frustration exhibited by the participants at continually trying to meet a
professional standard of care when not all of the perceived supports to ensure success
were in place.

Conclusions
The following constitute the significant conclusions I have drawn from the findings of
this study:

1. Patient educators in this study believe that there is a discrepancy in the
   practice of health education between English and non-English speaking
   patients.

2. Patient educators in this study believe that they have a professional
   responsibility to provide adequate and appropriate health education for non-
   English speaking patients.

3. Although the educators in this study used a variety of creative strategies to
   teach non-English speaking patients, they lacked knowledge of the cultural
   foundations of teaching this diverse population.

4. Participants in this study had little or no foundational knowledge in principles
   of adult education.
5. The educators in this study sometimes felt it was necessary to go extraordinary lengths to provide for the educational needs of non-English speaking patients.

6. All of the participants in this study experienced distress when they were unable to provide the necessary skills, knowledge, or information for a non-English speaking patient or family.

7. Although the experience of teaching non-English speaking patients is unique to each educator within this study, there are sufficient similarities in their experience to provide a foundation for nursing knowledge about teaching non-English speaking patients and for future discussion and exploration about this topic.

8. Patient educators in this study felt strongly that many administrators are lacking understanding and acknowledgement of the profound difficulty associated with the exchange of ideas between non-English speaking patients and themselves.

9. A variety of factors influenced the outcome of each encounter between educator and non-English speaking patient or family. These factors arose from attributes, such as experience and support, of the educators, non-English speaking patients and families, administration, and sometimes from the nature of the educational need.
Implications

The findings of this study have implications for a wide cross-section of nursing including nursing practice, nursing education, patient education, and research. In addition, its implications hold a challenge for those in health administration.

Nursing Practice

Despite the fact that standards exist for the care of all patients' regardless of diversity or disability and equal access to health care is a fundamental tenet of Canadian values, participants in this study struggled with the implementation of these goals. The participants in this study have with enthusiasm shared their knowledge and expertise with an array of patients. In the recent past, owing to the growth in the numbers of non-English speaking patients, the increased complexity of the knowledge and information required for each patient, and the lack of knowledge of different cultures, these dedicated patient educators have become discouraged about their ability to provide an expected standard of care to non-English speaking patients and their families. By giving voice to the difficulties that lead to educators' unpredictability and inconsistency in teaching non-English speaking patients, this study may give us cause to more closely examine the resources that are needed to support these patient educators and this vital component of patient care.

As evidenced by the experiences of the participants, without adequate communication and comprehension we are stymied in our endeavors to provide information to the patient and family. As indicated by the past, the onus of preparing patients and families to manage and treat a burgeoning degree of health related consequences falls inevitably to nursing. Moreover, as the findings of the study
indicate, that to maintain the standards of our profession and attend to the needs of patients and their families we must continue to develop new and better ways to enhance channels of communication, particularly those that are not solely grounded in the written and spoken word.

The findings of this study highlight the interrelationship of resources and support, and to the ability of non-English speaking patients to actively participate in their own care and take part in the management of their illness or injury. Providing individualized patient care requires that the educators of today become familiar with a wide range of patients’ languages and cultures. Another real challenge for nursing today is associated with the new constraints on our health system that inhibit educators’ ability to take the time that is needed to learn about and conduct teaching of non-English speaking patients and their families. It will take strong voices and commitment by nurses to communicate to institutional and government administrative personnel the needs of nursing educators and those of non-English speaking patients, particularly those who are unable to speak for themselves. Patient educators will need to present an articulate, well constructed, evidenced-based case that will illuminate the issues of diversity, difference, and disparity in patient education as they have experienced it.

Nursing Education

The findings of this study serve as a challenge to nursing educators to examine the status quo of the educational system in its depiction of patients as ‘Euro-western’ and ‘white’. It suggests that a new reality of great ethnic diversity is already upon us and academe has a responsibility to its newest members (and returning
alumnae) to accurately reflect the demographics of the present patient population of Canada. It also illustrates the need for the inclusion of basic principles of adult education in the curricula of nursing today, whether as a course in its own right or as part of a continuing educational stream. The responsibility to supply a cadre of well-trained and ethnically aware patient educators grows daily, as the acuity of discharged patient increases. It is in the area of nursing education that the time, commitment, energy, and creativity lie, which can create the structure on which to base a foundation of learning that accurately reflects our patient population and helps us to adjust our practice to address evolving paradigm.

Another pivotal issue for the enhancement of patient education for non-English speaking patients is providing nurse educators with a foundation in the principles of adult learning and theories of education. As patient education is the function of every nurse to some degree, perhaps the inclusion of such material in the basic education of the generalist nurse should be explored. Barring this, post-graduate courses specific to patient education could be offered. Regardless of the format, some attention to education of nurses about principles of adult education should be contemplated by those that are responsible for educating the nurses of the future and providing continuing education for experienced nurses.

Nursing Research

The findings of this study have major implications for nursing research. The first relates to the conundrum of research that studies referring to a specific subject (smoking, cardiac events, or post-surgical patients) are indicative of only one aspect of the population at large. Unfortunately, the exclusion criterion for most research
automatically eliminates most ethnic diversity and all participants who are unable to speak, fully comprehend, and write English. Although being able to communicate one’s thoughts and ideas are integral to scholarly inquiry we are imprisoned by the narrowness of our vision in this model. As the landscape of our population evolves, the knowledge that we implement to refine our practice will become outmoded if we do not discover a way to incorporate these changes into our consciousness. There is no doubt that inclusion of populations that are different from ourselves is difficult, particularly when language and culture are the barriers that we must surmount. Nevertheless, to avoid this reality is to ignore the future and relegate ourselves to inevitable devolution if not demise.

To expand on this concern, this study examined the issue of barriers to the education of non-English speaking patients from the perspective of the patient educators. The next logical step in this inquiry is to examine the same issues from the perspective of the patients. The difficulties related to this potential study include not only language specific but culturally appropriate interviewers. In addition, translators and reviewers along with the investigators need to be knowledgeable about the culture of the proposed participants of such a study. Despite the fact that none of this is likely to be easy, I strongly suggest that this and other studies that include a diverse participant population are an appropriate and necessary facet of nursing research in the future.

There is also the fact that this, albeit small, study will add to the remarkably meager collection of information on the education of non-English speaking patients.
This study may inspire another neophyte researcher to examine this question in another environment and confirm or refute the conclusions herein.

Nursing Administrators

One of the more significant findings of this study is the effect of administrative support for patient education. The participants strongly believed that their ability to provide the education critical to non-English speaking patients was dependant on the support of the institution's administration. The support discussed ranged from professional interpreters to providing additional time and/or staff for education of non-English speaking patients. It was clear from the participants that when an administration is "on board" regarding the importance of equal care for non-English speaking patients, the possibilities for participation of this group in self care and decision making increase. Clearly, the ability for the patient educators to take the time needed to properly attend to the specific needs of non-English speaking patients can only be enhanced by an administration that is committed to equality of care and willing to explore creative and effective methods to provide appropriate service to non-English speaking patients. Unfortunately, in these days of fiscal restraint the likelihood of an increase in resources for the underserved and least vocal of our patient populations grows less and less. Even so, the significance of the impact of support from institutional administrations on the outcomes of patient education for non-English speaking patients needs to be communicated in a strong, logical, evidenced-based manner. I believe that this study can assist in that endeavor.

Another significant implication for nursing administrators is the lack of cultural diversity in key positions of nursing. As illustrated in this study, this deficit
can have significant consequences. Although a concerted effort to hire qualified nurses of a similar ethnic background to the most common minority in an area would not eliminate the difficulties associated with linguistic barriers, it would certainly demonstrate an acceptance of diversity and provide an easily accessible source of knowledge and decrease the need for professional interpretive services.

Conclusion

In this study I have explored the barriers that language can pose to patient education from the perspective of the patient educator. If nurses are to continue to provide all patients with the knowledge and skills to implement self care and to take part in decisions regarding their care, this study illustrates the need to broaden our understanding of educational strategies, methods of communication, cultural differences, and ways to enhance administrative support. Despite the limitations of this study, I believe that it contributes to new nursing knowledge about the education of non-English speaking patients, the barriers that are imposed by language, the strategies used to promote the teaching of this patient population, and the supports necessary to provide quality patient education for non-English speaking patients.


Administration at 822-8598 if I have any questions or concerns about my rights or treatment in the research study at any time.

Any questions that I presently have about this study have been answered and I have received a copy of this consent for my own records.

Authorization:

I ____________________________, have read this letter of information and consent and have decided to participate in this research study. My signature indicates that I give permission for the information I provide from interviews or focus group to be used for publication in research articles, journals, books, or teaching materials and for secondary analysis when appropriate.

Participant Signature ____________________________ Date ____________________________
Appendix C

Potential Trigger Questions for Open-Ended Interview

1. Can you tell me about your experience with teaching limited English proficient and non-English speaking patients?
2. Do you encounter any problems unique to limited English proficient or non-English speaking patients?
3. What difficulties did you observe that non-English speaking patients faced?
4. What strategies did you use to try to overcome some of the problems?
5. How successful were any strategies in overcoming obstacles/difficulties?
6. Have you ever used pictures to assist the learning of non-English speaking patients? Can you tell me about the experience?
7. What resources are available for you to use when teaching limited English proficient and non-English speaking patients?
8. Does administrative support affect your ability to educate limited English proficient and non-English speaking patients? In what way?

Demographic inquiries will also be made such as: age, education, type of experience (group/individual), type of program, ethnicity of population, etc.)