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The Effects of the Use of Medical Interpreters Amongst the Latina Population in the Context of Sexual and Reproductive Health

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THE EFFECTS OF THE USE OF MEDICAL INTERPRETERS AMONGST THE LATINA POPULATION IN THE CONTEXT OF SEXUAL AND REPRODUCTIVE HEALTH

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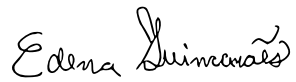

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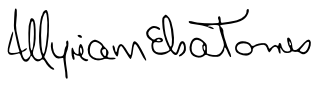

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Thesis Summary

Latinas face many challenges living in the United States and, as a result, have many adverse health outcomes. This thesis seeks to examine whether medical facilities using certified medical interpreters and requiring cultural competency training for their staff can reduce the cultural and communication barriers limited English proficiency (LEP) Latinas experience when receiving sexual and reproductive health care services. An integrative literature review was conducted to assess barriers in Latina sexual and reproductive health and the use of interpreters in this context. The study found several significant themes that led to barriers in Latina sexual and reproductive care, as well as barriers to adequately utilizing interpretation services. The findings illuminated the need for further certification requirements and enforcement for interpreters, as well as greater cultural competency for health care providers.

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Following the completion of this project, I feel better prepared as a future clinician to work with interpreters to provide the best care for my Latina patients. I have realized the importance of cultural competency training and the value of the interpreter as a member of the health care team. I hope that my research can contribute to the evidence for the expansion of interpretation services and that the importance of these services will be realized. It is my hope that all patients will receive quality and accessible care in their primary language.

Abstract

The Latino population in the United States is large and consistently growing. These individuals, due to cultural and systemic factors, are at greater risk for a variety of health problems, especially in the context of sexual and reproductive health. Many of these patients may not speak English as their first language and thus need to access interpretative services to receive care. This study sought to examine whether medical facilities using certified medical interpreters and requiring cultural competency training for their staff could reduce the cultural and communication barriers LEP Latinas-experience when receiving sexual and reproductive health care services. An integrative literature review was conducted and revealed several key themes that revealed significant barriers to Latina sexual and reproductive care, as well as barriers to proper utilization of interpretative services. The findings of this study support the need for cultural competency training amongst medical professionals and the need for better enforcement of consistent interpretation services.

Introduction

The term “Latino” refers to individuals whose family origins are traced back to countries in Latin America, such as Mexico, Central and South America, Puerto Rico, Cuba, and the Dominican Republic (Chong, 2002). The term “Hispanic” was created by the United States (US) Census Bureau to describe individuals whose native language is Spanish or whose family origin was traced back to Spain (Chong, 2002). Many Latinos do not personally identify as Hispanic, as they have no connection to Spain (Chong, 2002). Therefore, when referring to individuals from Latin America, it is more appropriate to use the word Latino. When describing a female specifically, the term Latina should be used (Chong, 2002).

According to the US Census (2018), Latinos made up 18.1% of the national population as of July 2017. The Latino population is predicted to exceed 100 million by 2050 (Yawman, et al., 2006). The Southern region of the US has seen the most growth within the Latino population with population percentages increasing 26% from 2010 to 2019 (Noe-Bustamante, Lopez, & Krogstad, 2020). Although the median age of Latinos has recently increased to 30, they are still among the youngest racial or ethnic groups in the US (Noe-Bustamante, et al., 2020). The birth rate for Latinas has fallen 25% since 2000 (Livingston, 2019). However, in 2017 the birth rate for foreign born Latinas was 82.3 per 1000 women compared to 55.8 per 1000 women for white females living in the US (Livingston, 2019). With the rapidly growing Latina population, there are often not enough resources or infrastructure to cater to their health care needs, especially in the context of interpretation services (Mann, et al., 2016).

Latinas are at greater risk for many diseases and health problems than their non-Hispanic white counterparts (Garcia-Jimenez, Calvo-Friedman, Singer, & Tanner, 2019). Racial and ethnic minorities often have higher incidence of and morbidity from chronic diseases (Garcia-

Jimenez, et al., 2019). Along with higher rates of chronic diseases, Latinas in the US experience negative sexual and reproductive health outcomes compared to their white counterparts (Mann, et al., 2016). For example, Latinas have a human immunodeficiency virus (HIV) rate three times as high as non-Hispanic white women, and their incidence rates for gonorrhea and chlamydia are over twice that of white women (Mann, et al., 2016). Additionally, over 50% of Latina pregnancies are unintended, compared to 40% of pregnancies in white women (Mann, et al., 2016). Latinas are disproportionately subject to systematic barriers to accessing contraception, sexual education, prenatal care, and cancer screenings (Fortuna, et al., 2019). Latinas may also lack autonomy regarding their sexual and reproductive health and decisions due to cultural practices of being submissive to their husbands when married and maintaining their virginity when they are single (Fortuna, et al., 2019).

These disparities can be attributed to many factors that minority individuals face in accessing health care in the US, a main factor being limited English proficiency [LEP] (Garcia-Jimenez, et al., 2019). LEP is defined as having a primary language other than English, and an ability to read, write, or speak English less than ‘very well” (Garcia-Jimenez, et al., 2019). Being unable to speak the same language as the provider, many patients may not feel that they can adequately explain their symptoms or understand their physician’s responses. Language barriers may lead to a lower quality of care. Being unable to comprehend their physician’s education and treatment plan due to a language barrier, may lead to poor patient satisfaction, poor compliance, and underuse of services for LEP patients (Timmins, 2002). Additionally, feeling misunderstood or unable to communicate due to a language barrier may cause the patient to be hesitant to return for follow-up (Meetze, Messias, & Torres, 2012).

The health care of Latinas is not only affected by language barriers, but cultural barriers as well (Chong, 2002). Many Latinas may have a high regard for authority and may agree with physicians in order to be respectful even when they may not understand what was said (Poma, 1983). Additionally, Latinas may have nontraditional ideas regarding the causes of illness from their home country, which non-ethically concordant physicians may not understand (Poma, 1983). Sexual and reproductive health can be viewed differently in the Latina culture compared to the US. For example, in many Latin American cultures, openly discussing sex is taboo and females may be uncomfortable discussing sex directly with their provider (Cashman, Eng, Simán, & Rhodes, 2011). In fact, single Latina women may not want to submit to procedures, such as a pelvic exam, that are seen as routine in the US (Poma, 1983). There is a high value of virginity in the Latina culture, so many may not want to submit to a pelvic exam unless it is absolutely, medically necessary (Poma, 1983). Many Latinas may even consider parts of the body like the neck, back, hips and thighs to be private in addition to the breasts and genitals (Chong, 2002). Providers must take these cultural considerations into account when they are interacting with and treating Latinas.

Latinas report the highest levels of patient satisfaction with the use of a bilingual, and bicultural interpreter who can not only accurately translate, but mediate cultural differences (Wu, Leventhal, Ortiz, Gonzalez, Forsyth 2006). However, oftentimes professional interpretation services with bicultural interpreters may not even be used due to costs associated with using interpreters, time inefficiency, use of nonprofessional interpretation, or reliance on suboptimal language skills of the patient or provider (Yawman, et al., 2006). Already busy and overwhelmed, providers may be unwilling to spend extra time locating interpretation services and many physicians have the impression that interpreted visits take longer (Fagan, Diaz,

Reinert, Sciamanna, & Fagan, 2003). This may lead to reliance on ad hoc interpreters, such as family members, which are found to lead to worse health outcomes than the use of professional services (Karliner, Jacobs, Chen, & Mutha, 2007). Ad hoc interpreters are untrained individuals who are asked to interpret for a patient visit (Karliner, et al., 2007). These can be bilingual staff members of the health care facility but are often family members of the patients (Karliner, et al., 2007). Many providers may be inclined to overuse ad hoc interpreters as they are easy to access, and do not have to be compensated specifically for this role. However, the use of ad hoc interpreters not only poses competency issues and the risk of the mistranslation of information but can also pose privacy violations (Garcia-Jimenez, et al., 2019).

Title VI of the Civil Rights Act of 1964 states that all patients have a right to access medical care in their native language (Jacobs, Ryan, Henrichs, & Weiss, 2018). Antidiscrimination provisions under this act require any "health program or activity" which receives "federal financial assistance" to provide accurate interpretation services at no cost to the patient (Jacobs, et al., 2018). Many health care providers are still not aware that they have these responsibilities and are not sufficiently held accountable (Chen, Youdelman, & Brooks, 2007). Currently, the US Department of Health and Human Services (2016) requires several competencies for "qualified interpreters," such as knowledge of specialized terminology and ethics for translating accurately and impartially. However, there is currently no requirement of any national certification to serve as a qualified medical interpreter. This leaves interpreter qualifications at the discretion of the hospitals or clinics that are employing interpreters, which may not possess significant understanding of the importance of these services and the skills needed to perform the job effectively. Because the health and legal system of the US may be foreign to many Latinas, they may not be aware of their right to receive interpretation services

(Timmins, 2002). Lack of knowledge and resources to access legal representation leads to few Latinas exercising this right (Timmins, 2002).

Despite the positive results associated with the use of professional medical interpreters compared to the lack of any interpretation services or the use of ad hoc interpreters, patients are still found to prefer encounters with ethnically concordant physicians (Abraído-Lanza, Céspedes, Daya, Flórez, & White, et al., 2013). Ethnically concordant physicians are more likely to have the adequate Spanish-speaking skills for health care communication than non-Latino bilingual physicians, and may share a common cultural background with Latinas, further enhancing their communication (Steinberg, Valenzuela-Araujo, Zickafoose, Kieffer, & DeCamp, 2017). Nonetheless, ethnically concordant physicians may not be available for every Latina patient, as this population is rapidly increasing. According to the Association of American Medical Colleges (2019), in 2018 Hispanic individuals made up only 5.8% of the physicians in the US. In fact, there has actually been a decline in the number of Latino physicians over the past 30 years (Steinburg, et al., 2017).

Racial and ethnic minority children may be more likely to live in impoverished areas and attend under resourced schools, preventing them from accessing a career in medicine as easily as white children (Sánchez, Poll-Hunter, & Acosta, 2015). Latino students are not being equipped at the primary school level with the same skills and opportunities to pursue medicine as white children due to low resources. Moreover, Latinos are underrepresented in bachelor's degree programs (The Postsecondary National Policy Institute, 2020). In fall 2018, 20% of Latino students were enrolled in a public 4-year bachelor's degree program compared to 56% of white students (The Postsecondary National Policy Institute, 2020). Entering medical school requires the completion of a 4-year degree, and without this education Latinos cannot pursue medical

degrees. Country of origin also has an effect on whether or not Latinos receive a 4-year bachelor's degree. Immigrant Latinos are even less likely to receive a bachelor's degree than US born Latinos (The Postsecondary National Policy Institute, 2020). Many factors could be contributing to these lower education rates; however, socioeconomic status and family income are likely prominent barriers. Latino students may present financial challenges to entering a 4-year college followed by a medical degree program, as 50% of dependent Latino students come from families that make less than $50,000 a year (The Postsecondary National Policy Institute, 2020). Overall, there are significant educational and economic barriers that need to be addressed in order to increase the number of Latino physicians.

Because of this shortage of ethnically and culturally concordant physicians, and the frequent misusage of interpretation services, it may be beneficial to incorporate cultural competency training into the medical school curriculum to equip non-Latino physicians with the skills to work effectively with the Latina population. Cultural competency is the ability of the health care provider to understand and respond to patient cultural needs brought to an encounter (Chong, 2002). Cultural competency training can include information on working with interpreters, background on patient's countries of origins, and information on patients' communication styles (Hudelson, 2005). Cultural competency can improve the patient-provider relationship and facilitate better communication when Latinas are being treated by non-Latino physicians.

This thesis seeks to examine whether medical facilities using certified medical interpreters and requiring cultural competency training for their staff can reduce the cultural and communication barriers LEP Latinas-experience when receiving sexual and reproductive health care services. As sexual and reproductive health is a sensitive topic, many Latinas may not feel

as comfortable being open and honest with a provider, which could be exacerbated by having an additional individual in the room or having a language barrier to communication. Additionally, using an interpreter may weaken the patient-provider relationship, as patients are not able to communicate with the provider directly. Therefore, patients may be more hesitant to share about sensitive issues. Having more physicians that could understand Latina culture and could work effectively with interpreters could improve the sexual and reproductive health of Latinas and allow more resources to be contributed to other factors that create disparities in Latina health.

Methods

An integrative literature review of a variety of existing scholarly publications was conducted between January 2020 and March 2021. Over 25 different studies from the year 1983 to the year 2020 were analyzed and 15 were selected for review. The current requirements and regulations for medical interpreters were examined. Additionally, the use of medical interpreters amongst the Latina population, disparities in Latina sexual and reproductive health, and how cultural barriers may affect the sexual and reproductive health of Latinas were analyzed. Secondary data was located using the University of South Carolina Thomas Cooper Library database, such as PubMed and CINAHL databases, which were chosen based on their relevance to the topic. Various combinations of search terms were used including ‘interpretation services AND reproductive health,’ ‘medical translation AND Spanish,’ “Latina AND reproductive health,’ ‘cultural competency AND medical school,’ and ‘patient provider relationship AND Latina.’ In order to be included in this review, articles had to meet the criteria of being published in a peer-reviewed scientific journal, involving Latina or immigrant populations, and focusing on interpretation services or cultural competency in the treatment of Latinas.

Results

A total of fifteen studies were included in this review. Nine out of the fifteen studies focused on the issues and disparities in Latina sexual and reproductive health as a result of lingual or cultural barriers and the patients themselves. The nine studies that focused on Latinas and barriers to sexual and reproductive care were all qualitative. Three out of the nine studies consisted of interviews, two out of the nine consisted of focus groups, three out of the nine consisted of surveys, and one out of the nine consisted of a multi-method approach combining observation and interviews. All nine of these studies described various cultural or linguistic barriers that Latinas faced in seeking health care services. Three of the nine studies focused specifically on sexual or reproductive health and barriers to care. The remaining six of the nine studies focused on general health issues for Latinas.

Six out of fifteen studies focused on the interpreters, the proper use of interpreters by health care providers and relationship, and the interpreters' relationship with health care providers. All of the six studies involved interviews with medical interpreters or providers regarding the interpreter's role and barriers they faced in performing this role were qualitative.

Cultural and Other Barriers to Sexual and Reproductive Health Services

There were several common themes amongst the nine studies that focused on barriers to sexual and reproductive care for Latinas: language as a barrier to care, negative effects on the patient-provider relationship due to barriers and interpreter use, the preference for a cultural or ethnically concordant provider, cultural barriers to sexual and reproductive health prevention, and discrimination in seeking health care services.

Language as a Barrier to Care

All nine of the studies that focused on Latinas and barriers to sexual and reproductive care identified language as a significant barrier to care. Language barriers may lead to frustration amongst health care providers in their interactions with Latinas, which can cause Latinas to be more hesitant in disclosing information (Julliard, et al., 2008). Additionally, a language barrier may lead to patients leaving a health care facility without fully understanding the information they were given or to signing consent forms without any form of translation (Meetze, et al. 2012).

Language barriers often led to the use of an interpreter, which created more issues and barriers to effective care. One of the studies found that patients felt uncomfortable with interpreter in room, making them less likely to share information with the provider (Julliard, et al., 2008). Two of the studies found that patients felt the interpreter could not adequately explain their symptoms (Cashman, et al., 2019 & Julliard, et al., 2008). This can leave the patient frustrated, affecting their communication, and decreasing their quality of care. One study found that patients communicating through an interpreter were less likely to understand their discharge status or any discharge directions they were given (Baker, Hayes, & Fortier, 1998).

Latinas expressed concern that ad hoc interpreters did not possess the vocabulary needed for medical interpretation (Garcia-Jimenez, et al., 2019). As a result of certification processes not being strictly enforced and ad hoc interpreters are often being used, medical vocabulary and processes may be too difficult for these interpreters to explain (Meetze, et al., 2012). Inaccurate translation can exacerbate frustration and misunderstanding, as well as lead to an increase in visit time. Two of the studies found that patients had concerns about confidentiality with the use of interpreters, especially when ad hoc interpreters were used (Julliard, et al., 2008 & Garcia-Jimenez, et al., 2019). Already being sensitive to discussing sensitive issues around sexual and

reproductive health, Latinas may be even more hesitant to be transparent if they are not sure that their confidentiality is upheld.

Negative Effects on Patient-Provider Relationship

Six out of these nine studies found that the language barrier and cultural discordance between the patient and the provider had negative effects on the patient-provider relationship, which ultimately has an effect on the overall quality of care (Abraído-Lanza, et al., 2011; Fry-Bowers, Maliski, Lewis, Macabasco-O'Connell, & DiMatteo, 2014; Garcia-Jimenez, et al., 2019; Julliard, et al., 2008; Meetze, et al., 2012; Sheppard, Williams, Wang, Shavers, & Mandelblatt, 2014). Culture influences individuals' views on illness and suffering and thus, is a crucial part of any health care visit (Abraído-Lanza, et al., 2011). Poor communication and patient outcomes can result due to lack of cross-cultural skills and cultural awareness amongst providers (Abraído-Lanza, et al., 2011). Latinas with a language barrier should be provided with interpretation services during all parts of an encounter. However, three of the studies found that patients using an interpreter reported worse patient-provider interaction or relationship than those patients who were seen without an interpreter (Baker, et al., 1998; Julliard, et al., 2008; Garcia-Jimenez, et al., 2019). Patients felt that using an interpreter decreased the interpersonal element of interacting with their medical provider and led to limited communication about their medical problems (Garcia-Jimenez, et al., 2019). With the interpreter in the room, the provider may be tempted to maintain eye contact with the interpreter instead of the patient, furthering decreasing the interpersonal interaction with the patient and missing key information regarding patient body language and expressions (Baker, et al., 1998). When cultural expectations like eye contact are not met, confidence in the provider decreases, negatively affecting the patient-provider interaction (Fry-Bowers, et al., 2014). Using an interpreter made patients more likely to report

that their provider was “less friendly, less respectful, and less concerned for them as a person” (Baker, et al., 1998). When patients are less satisfied with their provider, they have less intention to comply with provider recommendations and are more likely to frequently change providers (Baker, et al., 1998).

Preference for Ethnically Concordant Providers

Two out of the nine studies found that Latinas preferred an ethnically or culturally congruent provider (Garcia-Jimenez, et al., 2019; Abraído-Lanza, et al., 2011). Latinos are more likely than patients of other races to prefer an ethnically concordant provider (Abraído-Lanza, et al., 2011). Patients who saw a Latino provider were less likely to report a communication difficulty (Abraído-Lanza, et al., 2011). Having a Latino physician is associated with better patient-provider interactions since they are familiar with cultural norms (Abraído-Lanza, et al., 2011). Latinas noted that, with language concordant providers, they felt more open to communicating about and elaborating on their health problems (Garcia-Jimenez, et al., 2019). They felt more trust and familiarity when they were able to speak their native language with their provider which led them to be more open about their sexual and reproductive health (Garcia-Jimenez, et al., 2019).

Culture Barriers to Sexual and Reproductive Health Prevention

Four of the nine studies found that there were cultural barriers to proper sexual and reproductive prevention and health in the Latina community (Cashman, et al., 2019; Julliard, et al., 2008; Mann, et al., 2016). Latinas, especially recent immigrants, may have a lack of knowledge regarding sexual and reproductive preventative services and a lack of awareness of where to seek out these services (Mann, et al., 2016). Latinas may find the US healthcare system

more complicated and expensive than the healthcare system in their country of origin, creating further barriers for seeking care (Mann, et al., 2016).

Additionally, many cultural norms may affect Latina's desire to communicate regarding sexual and reproductive health issues (Julliard, et al., 2008). For example, discussion of sexual and reproductive health at home may be limited, and Latinas may even be reluctant to use certain words to describe their reproductive anatomy and health problems (Cashman, et al., 2019; Julliard, et al., 2008). There are a limited number of sexual education programs offered in Spanish, leading to a lack of knowledge regarding many aspects of sexual and reproductive health for LEP patients (Cashman, et al., 2019). Due to modesty, Latinas may be reluctant to discuss sexually transmitted diseases and sexual difficulties, especially if the physician is male (Julliard, et al., 2008). Additionally, due to cultural norms from their country or culture of origin Latinas may be resistant to physical exams, especially gynecological exams (Cashman, et al., 2019). They may not wish to receive these exams and may try to avoid them unless they are absolutely necessary (Julliard, et al., 2008). Preventative testing and exams are a large part of sexual and reproductive health; many Latinas may be missing out on these procedures due to cultural barriers that are not being addressed.

Discriminatory Experiences

Three of the nine studies found that Latinas faced discrimination due to being unable to speak English when seeking health care services (Cashman, et al., 2019 & Sheppard, et al., 2014; Mann, et al., 2016). Many Latinas who experienced discrimination in the health care setting reported that they delayed seeking health care as a result (Cashman, et al., 2019; Sheppard, et al., 2014; Mann, et al., 2016). Additionally, discriminatory experiences in health care visits may lead to reduced utilization of preventative services (Sheppard, et al., 2014). The patient-provider

interaction is the most significant predictor in the report of a discriminatory experience (Sheppard, et al., 2014). Latinas reported feeling that their provider did not listen to them because of their ethnicity (Sheppard, et al., 2014). Making providers and clinic staff aware of Latina culture norms and values like “personalismo” and “respeto” can improve the patient-provider interaction and decrease the chance of a perceived discriminatory experience (Sheppard, et al., 2014).

In one study, Latinas felt that they were discriminated against at their health care visit, even by other Latinos, for being unable to speak English (Cashman, et al., 2019). Latinas report longer wait times, bad attitudes, and lack of attention from clinic staff, all of which had an influence on their decision to seek subsequent care (Mann, et al., 2016). A study found that oftentimes LEP patients are handed forms in English without any instruction or translation, leaving patients unable to complete the forms or forced to ask another native speaker for help, compromising their confidentiality (Meetze, et al. 2012). The lack of health insurance, associated costs of health care, or difficulties navigating the US health care system can also prevent patients from receiving services, especially those of high quality (Cashman, et al., 2019).

Interpreter Role Conflict and Interaction with the Provider

The six studies focused on interpreters used qualitative methods to assess provider views on interpreters and the use of Spanish in practice. Overall, the standard role for an interpreter is that of the conduit: neutral, faithful, and passive (Hsieh & Kramer, 2012). Interpreters should translate word for word and assume an invisible presence within the patient-provider interaction (Hsieh, 2006). Despite this, all of these studies found that provider and patients’ expectations often prevented interpreters from performing this role accurately (Hsieh, 2006; Hsieh & Kramer, 2012; Hudelson, 2005; McDowell, Messias, & Estrada, 2011). There were several key themes

prevalent amongst all of the six studies that focused on interpreters' roles: patient and provider understanding of the interpreter's role, the need to provide emotional support, the desire to advocate for the patient and mediate cross-cultural communication, power relations between the interpreter and the provider, and the need for interpreters and cultural competency training for health care providers.

Understanding of Interpreter's Role

In a study, providers classified interpreters in four main roles: language conduit, flow manager, relationship builder, and cultural insider (Schwei, Guerrero, Small, & Jacobs, 2019). Many providers who participated in this study noted that high quality interpretation requires more than direct language transmission (Schwei, et al., 2019). Many providers expect the interpreter to serve only as a conduit, but then continue to ask them to perform duties outside of this role, leading to role conflict for the interpreter. For example, though the provider may ask the interpreter to translate word for word, they might then ask them to omit information that is irrelevant to the questions that they ask (Hsieh & Kramer, 2012). Additionally, providers may speak in front of the patient knowing they do not understand, expecting the interpreter not to translate some of the information that they would not want the patient to hear (Hsieh, 2006). After being asked to translate word for word, the interpreter may feel conflict on whether or not to relay this information to the patient, even though there is some underlying implication that they should not (Hsieh, 2006).

All of the studies found that a lack of understanding of the conduit role amongst patient and providers led to role conflict for the interpreter (Hsieh, 2006; Hsieh & Kramer, 2012; Hudelson, 2005; McDowell, et al., 2011). Despite this, interpreters often reported being asked to skip their introduction and explanation of their role due to provider time constraints (Hsieh &

Kramer, 2012). If more interpreters were allowed to explain their role at the beginning of each interaction, provider and patient understanding of the interpreter's role may increase.

The Role of Emotional Support in Interpretation Services

Interpreters noted that they often felt the need to provide emotional support to their patients in order to facilitate communication, even though this is not necessarily part of the conduit role (Hsieh, 2006; Hsieh & Kramer, 2012; McDowell, et al., 2011). Interpreters felt that this emotional support and compassion was necessary to gaining trust with the patient in order to get them to effectively communicate (Hsieh, 2006; McDowell, et al., 2011). However, emotional support is not a part of the conduit role, and there is some concern that the interpreter showing emotion could cause the patient to favor the interpreter and negatively affect the patient-provider relationship (Hsieh & Kramer, 2012). Additionally, some interpreters noted that the provider desired for them to show emotional support and form a closer relationship with the patient if it served their treatment agenda and could result in valuable information (Hsieh & Kramer, 2012). Many interpreters are facing an internal debate on whether their emotional support is valuable or detrimental to the patient-provider interaction and are not being given adequate or consistent direction from health care providers.

Patient Advocation and Cross-Cultural Mediation

As a conduit, the interpreter is expected to maintain neutrality and not contribute to the conversation between the patient and provider (Hsieh & Kramer, 2012). This leads to conflict within the interpreter when they can sense that the patient is misunderstanding and omitting information due to cultural incongruence (Hsieh, 2006; McDowell, et al., 2011). Many interpreters felt the need to advocate for their patients and make sure the right information was being shared and understood but did not want to violate their conduit role (Hsieh, 2006;

McDowell, et al., 2011). Interpreters may need to act as a "cultural broker," using cultural frameworks to facilitate cross-cultural communication between the patient and provider (McDowell, et al., 2011). Interpreters noted that there are many times that they could offer valuable information regarding cultural practices of the patient, but there is conflict over whether or not they should share this information with the provider (Hsieh, 2006; McDowell, et al., 2011).

Power Dynamics Amongst Interpreters and Providers

Interpreters noted that the hierarchy and power dynamic between themselves and the providers for whom they worked often prevented them from commenting on the effectiveness of communication or pointing out issues following patient-provider interactions (Hsieh, 2006; Hsieh & Kramer, 2012; Hudelson, 2005). Providers may view interpreters as "tools," without needed opinions or perspectives, expecting them to interpret verbatim unless asked for further clarification (Hsieh & Kramer, 2012). Interpreters may also be pressured to conserve the provider's time due to institutional constraints and may be pressured to omit information or not perform all parts of their role, such as their formal introduction and explanation of their role in the encounter (Hsieh, 2006). Many interpreters had immense respect for providers and felt that it was the providers' role to ask them to elaborate on cultural issues but reported that the providers were unlikely to notice or address these barriers (Hudelson, 2005). This hesitance could cause the loss of valuable cultural insight for the provider that may have been able to improve patient outcomes.

Need for Interpreters and Cultural Competency Training Amongst Providers

Despite Title VI of the Civil Rights Act of 1964 requiring health care facilities to provide accurate interpretation services to their LEP patients, it is not always enforced. A study provided

questionnaires to medical students and residents regarding their Spanish proficiency, their use of Spanish with LEP patients, and their use of an interpreter (Yawman, et al., 2006). This study found that professional interpretation services were used less often than other forms (ad hoc, electronic, provider language skills, etc.), 42% and 58% respectively (Yawman, et al., 2006). Additionally, the study noted that those participants with poor self-reported Spanish proficiency also reported frequently communicating with LEP patients without an interpreter (Yawman, et al., 2006). Most participants perceived that LEP patients received worse care than English speaking patients (Yawman, et al., 2006). All of this illuminates the need for professional interpretation services and greater regulation of provider Spanish use. The study also found that 85% of participants were willing to participate in further language studies and 80% of participants noted that it is possible they will use their Spanish (Yawman, et al., 2006). This study shows that providers are willing to invest in improving their language and cultural-competency skills.

Another study interviewed interpreters on patient-provider communication and how providers could be trained to facilitate better communication (Hudelson, 2005). Regarding the topics that cultural competency training for providers should be focused on, interpreters recommended that awareness of sources of misunderstanding, difficulties of medical translation, basic background knowledge of patients' country of origin, and adaptation to patient communication styles all be focused on (Hudelson, 2005).

Discussion

The purpose of this study was to examine the current barriers to Latina sexual and reproductive care, the use of interpreters and how this use contributed to or improved barriers, as well as how cultural competency training amongst health care providers could be used to address

these barriers. The intent of the study was to determine whether medical facilities using certified medical interpreters and requiring cultural competency training for their staff can reduce the cultural and communication barriers LEP Latinas experience when receiving sexual and reproductive health care services.

Findings of this review illuminated the issues that cultural and language barriers cause, leading to the need for comprehensive interpretation services. Likewise, the findings also revealed many of the previously hypothesized issues with interpretation services that may lead to further barriers in patient-provider communication. Language barriers were found to lead to frustration as well as misinformation. In order to cope with this, interpreters are used. As predicted, many of the studies found that interpreter use leads to other concerns such as confidentiality, mistranslation, and reduced transparency that may affect the health care visit. These potential barriers should be considered when establishing these services and utilizing them in the health care setting. Additionally, barriers can be exacerbated in the context of sexual and reproductive health due to cultural norms and practices surrounding these topics.

The findings of this study showed that interpreters can lead to barriers in the patient-provider relationship. Patients communicating through an interpreter may not feel as connected to their provider and may be reluctant to be honest and open. Further barriers in the patient-provider relationship are due to cultural differences. Providers may not understand Latina patients' cultural practices or views about illness. Patients may not understand the US health system and the customary interaction between patient and provider. All of this can contribute to poor patient interactions and worse health outcomes. Due to these barriers, many Latinas may prefer a culturally or ethnically congruent provider. These providers may be able to better understand and relate to Latinas, making them more comfortable, communicative, and willing to follow provider

advice. However, there is a shortage of Latino physicians. The next best option to ethnically concordant physicians is training non-ethnically concordant physicians to be culturally competent within the Latina population. While this cannot replace the experience of an ethnically concordant physician, it may be able to reduce cultural barriers to care.

Part of cultural competency training for providers should include information on how to effectively work with interpreters. Since interpreters may have a negative effect on the patient-provider relationship, physicians need to make an effort to improve their cultural competency skills and relate with the patient even when communicating through the interpreter. They should maintain eye contact and speak to the patient as though the interpreter is not in the room. Additionally, they should employ cultural norms like "personalismo," the ability to relate on a personal level during an interaction, which will make the patient more comfortable and open to sharing (Chong, 2002). Many Latinas may look for this quality in their provider and may not be comfortable with them if they feel they do not have it (Fry-Bowers, et al., 2014). Making providers aware of cultural values and norms such as this will allow them to facilitate better communication with their Latina patients. Additionally, if these cultural competency skills are utilized throughout health care facilities, Latinas may be less likely to report discriminatory experiences, which is another common theme found in this study. When providers take special care to acknowledge the patient's cultural differences and try to accommodate them, this could lead to a more comfortable environment for Latinas. If Latinas are comfortable and do not feel discriminated against, they will be more likely to seek out care from a facility and not avoid or delay an interaction. This may lead to better utilization of preventative services and may facilitate better relationships between Latinas and providers.

Amongst all of the studies that focused on interpreters' roles, there were several key themes: patient and provider understanding of the interpreter's role, the need to provide emotional support for the patient, the desire to advocate for the patient and mediate cross-cultural communication, and power relations between the interpreter and the provider. The findings of these studies illustrated the common misunderstanding of the interpreter's role. When interpretation services are being used, providers may not be using them correctly, which could potentially be a source of the negative outcomes associated with these services. In order to correct these errors, a definitive description of the interpreter's role needs to be established and enforced everywhere. This role needs to be stressed in certification programs. It may be of merit to require providers working with interpreters to undergo training themselves regarding the interpreter's role, since so many studies found that providers were misusing interpreters or causing role confusion. Interpreter role conflict, which occurs when the patient or physician does not adequately understand the interpreter's role, can lead to poor outcomes for the patient and ethical dilemmas for the interpreter. Mutual understanding of the interpreter's role within a patient interaction between the interpreter and the provider would likely address common barriers to interpreter use such as associated costs and time inefficiency (Yawman, et al., 2006). Mutual understanding will reduce the time spent in a visit and thus reduce the cost of using an interpreter as they are needed for a shorter amount of time.

The accepted standard role for an interpreter is that of the conduit: neutral, faithful, and passive (Hsieh & Kramer, 2012). However, based on findings from this study, the role of the interpreter may need to expand from solely that of a conduit in order to facilitate better patient-provider communication. Allowing the interpreter to have more authority to point out miscommunication or cultural misunderstanding could lead to better outcomes. With more

consistent and high-quality training, additional elements, such as cross-cultural mediation and patient advocacy, could be incorporated into the interpreter's training and role. A universal role for the interpreter needs to be established so that physicians can attain a better understanding of the role. The physician needs to be trained on the interpreter's role, how they should translate, and what they must not ask the interpreter to do. For example, based on the studies, they should not speak to the interpreter in front of the patient unless they want everything they said translated directly (Hsieh, 2006). Providers should not ask interpreters to omit any information so that no important information is lost. Additionally, providers should always allow interpreters to do a proper introduction at every encounter so that both the patient and provider completely understand the purpose and process of medical interpretation.

A common occurrence in the studies was that, though these were federally funded health care facilities, there was no enforcement of professional interpretation services. Many of the studies included data where bilingual staff or ad hoc interpretation services were used. These individuals may not have the adequate skills or knowledge to interpret correctly and facilitate accurate communication between the patient and provider. The studies that did include both types of interpretation services found that professional interpreters were preferred to ad hoc, illuminating the need to expand this field. Title VI of the Civil Rights Act of 1964 states that all patients have a right to access medical care in their native language and requires any "health program or activity" which receives "federal financial assistance" to provide accurate interpretation services at no cost to the patient (Jacobs, et al., 2018). The findings of this study showed that LEP patients may be seen by providers who are not adequately skilled in medical Spanish, further illustrating the need for professional interpreters in health care facilities (Yawman, et al., 2006). The laws are in place to require professional interpretive services, but more enforcement of these

laws is necessary. Since the current approach of leaving interpretation services up to the health care facility is not effective, this enforcement should come from the federal level.

The findings of the study indicate that cultural competency training for health care providers can be beneficial to their interactions with Latinas. Moreover, based on the articles in this study, many providers would be open to receiving additional language and cultural training (Yawman, et al., 2006). Therefore, an effective method of improving health care providers' cultural competency skills is implementing cultural competency into medical training. Implementing and enforcing cultural competency training in health care facilities can help to prevent cultural misunderstanding and promote cultural awareness, both decreasing barriers to care and improving outcomes. As can be seen in this study, cultural competency is essential to providing quality care to LEP patients as required by Title VI of the Civil Rights Act of 1964. Based on the findings of this study, cultural competency training for providers should include information about language and cultural barriers, communication styles, patient cultural norms, and how to work effectively with interpreters. While this training will definitely benefit Latinas, improving cultural-competency skills teaches providers better bedside manner and ways to further connect with their patients, improving trust and communication for all. Many providers may be willing to participate in this training if it is offered and incorporating it into medical school curriculum and other forms of health care provider education is an effective way to make it more accessible for a larger number of individuals.

Limitations

This study was not without limitations. This study consisted of a small sample size of articles, reflecting the current literature on this topic. As a result of Title VI of the Civil Rights Act of 1964 not being strictly enforced, there are limited studies of solely professional

interpretation services effects. Many of the studies contained data from both professional and ad hoc interpretation, which could have affected the results. Additionally, the studies had inconsistent settings and focuses. Although all studies focused on some aspect of Latina sexual and reproductive health, some of the studies focused on more specific topics like prenatal care. Qualitative data, like the interviews or surveys used in this study, can lead to bias due to the findings being self-reported. There is limited quantitative data on the effects of interpreters. Quantitative approaches to studying Latina sexual and reproductive health outcomes as a result of the use of certified interpreters and cultural competency training are needed.

Future Considerations

More research should be conducted to determine patient outcomes where professional interpretative services are utilized correctly, and certification is enforced. This study illuminated the need for the expansion of the interpreter's role to further facilitate patient-provider communication. Further research should focus on the essential tasks for interpreters and how to incorporate these tasks into a universally enforced role. As modification and expansion of the interpreter's role develops, research should be conducted on the additions to the role and their effectiveness. As more medical schools and health care facilities are incorporating cultural competency training into their requirements, more data regarding the effectiveness of this training and resultant patient outcomes will become available.

Conclusion

Though it would be inaccurate to claim that the use of interpretative services decreases the quality of care that Latinas receive, the system undoubtedly needs improvements. Studies illustrated that interpretative services are often of low quality and are underutilized. Stricter licensure and usage criteria need to be established for interpretative services. A nationwide

certification needs to be established and physicians and hospitals must be held accountable for providing all their patients with language-congruent care even if it comes at a greater cost and takes more time. Additionally, more providers need training on the specific role of the interpreter and how to work with interpreters efficiently. Latinas need to be made aware of their rights to interpretative services and their provider's legal obligation to provide these services. They need to be empowered to demand that they receive high quality services whenever they are needed.

Many cultural factors can affect the sexual and reproductive care for Latinas and studies have shown that a positive patient-provider relationship plays a crucial role in improving outcomes. Therefore, though the interpreter plays a vital role, the best care will come from culturally competent physicians. When physicians can understand the patient's culture, they will be able to work better with the interpreter to provide the patient with the best care. Incorporating this training in the medical school curriculum could benefit all patients of a racial or ethnic minority, allowing them to receive more equitable care. To account for all of the health care providers and staff that are already trained and practicing, cultural competency training could be incorporated into professional development and continuing education training within health care facilities. As a melting pot nation, with a growing Latina population, the US cannot allow large sects of its population to go without accessible medical care that is provided in their own language and is adaptable to their own culture. Effort needs to be made to give providers the skills to work effectively across barriers with patients of other languages and cultures.

References

Abraído-Lanza, A. F., Céspedes, A., Daya, S., Flórez, K. R., & White, K. (2013). Satisfaction with health care among Latinas. *Journal of Healthcare for the Poor and Underserved, 22*(2), 491-505. doi: 10.1353/hpu.2011.0042

Association of American Medical Colleges. (2019). Diversity in medicine: facts and figures 2019. *Diversity and Inclusion*. https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

Baker, D. W., Hayes, R., & Fortier, J. P. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical Care, 36*(10), 1461–1470. doi: 10.1097/00005650-199810000-00004

Cashman, R., Eng, E., Simán, F., Rhodes, S. (2011). Exploring the sexual health priorities and needs of immigrant Latinas in the southeastern United States: a community-based participatory research approach. *AIDS Education and Prevention, 23*(3), 236-248.

Chen, A. H., Youdelman, M. K., & Brooks, J. (2007). The legal framework for language access in health care settings: Title VI and beyond. *Journal of General Internal Medicine, 22*(2), 362-367. doi: 10.1007/s11606-007-0366-2

Chong, N. (2002). *The Latino Patient.* Intercultural Press.

Fagan, M. J., Diaz, J. A., Reinert, S. E., Sciamanna, C. N., & Fagan, D. M. (2003). Impact of interpretation method on clinic visit length. *Journal of General Internal Medicine*, *18*(8), 634–638. doi: 10.1046/j.1525-1497.2003.20701.x

Fortuna, L. R., Noroña, C. R., Porche, M. V., Tillman, C., Patil, P. A., Wang, Y., Markle, S. L., & Alergría, M. (2019). Trauma, immigration, and sexual health among Latina women:

implications for maternal-child well-being and reproductive justice. *Infant Mental Health Journal, 40*(5), 640-658. doi: 10.1002/imhj.21805

Fry-Bowers, E. K., Maliski, S., Lewis, M. A., Macabasco-O'Connell, A., DiMatteo, R. (2014). The association of health literacy, social support, self-efficacy and interpersonal interactions with health providers in low-income Latina mothers. *Journal of Pediatric Nursing, 29*(4), 309-320. doi: 10.1016/j.pedn.2014.01.006

Garcia-Jimenez, M., Calvo-Friedman, A., Singer, K., & Tanner, M. (2019). Patient experiences with the use of telephone interpreter services: an exploratory, qualitative study of Spanish-speaking patients at an urban community health center. *Narrative Inquiry in Bioethics, 9*(2). doi: 10.1353/nib.2019.0027

Hsieh, E. (2006). Conflicts in how interpreters manage their roles in provider–patient interactions. *Social Science & Medicine, 62*(3), 721-730. doi: 10.1016/j.socscimed .2005.06.029

Hsieh, E. & Kramer, E. M. (2012). Medical interpreters as tools: dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Education and Counseling, 89*(1), 158-162. doi: 10.1016/j.pec.2012.07.001

Hudelson, P. (2005). Improving patient–provider communication: insights from interpreters. *Family Practice*, *22*(3), 311–316. doi: 10.1093/fampra/cmi015

Jacobs, B., Ryan, A. M., Henrichs, K. S., & Weiss, B. D. (2018). Medical interpreters in outpatient practice. *Annals of Family Medicine, 16*(1), 70-76. doi: 10.1370/afm.2154

Julliard, K., Vivar, J., Delgado, C., Cruz, E., Kabak, J., & Sabers, H. (2008). What Latina patients don't tell their doctors: a qualitative study. *Annals of Family Medicine, 6*, 543-549. doi: 10.1370/afm.912

Karliner, L. S., Jacobs, E. A., Chen, A. H., Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research, 42(*2), 727-754. doi: 10.1111/j.1475-6773.2006.00629.x

Livingston, G. (2019). Hispanic women no longer account for the majority of immigrant births in the U.S. *Pew Research Center.* https://www.pewresearch.org/fact-tank/2019/08/08/hispanic-women-no-longer-account-for-the-majority-of-immigrant-births-in-the-u-s/#:~:text=Foreign%2Dborn%20Hispanic%20women%20have,for%20which%20data%20is%20available).

Mann, L., Tanner, A. E., Sun, C. J., Erausquin, J. T., Simán, F. M., Downs, M., & Rhodes, S. D. (2016). Listening to the voices of Latina women: sexual and reproductive health intervention needs and priorities in a new settlement state in the United States. *Health Care for Women International, 37*(9), 979-994. doi: 10.1080/07399332.2016.1174244

McDowell, L., Messias, D., Estrada, R. (2011). The work of language interpretation in health care: complex, challenging, exhausting, and often invisible. *Journal of Transcultural Nursing, 22*(2), 137-147. doi: 10.1177/1043659610395773

Meetze, E., Messias, D., & Torres, M. (2012). Prenatal care providers interactions with Latina patients: persistent communication barriers and gaps. *Journal of Health Disparities Research and Practice, 5*(3), 1-20.

Noe-Bustamante, L., Lopez, M. H., & Krogstad, J. M. (2020). U.S. Hispanic population surpassed 60 million in 2019, but growth has slowed. *Pew Research Center.* Retrieved from https://www.pewresearch.org/fact-tank/2020/07/07/u-s-hispanic-population-surpassed-60-million-in-2019-but-growth-has-slowed/

Poma, P. A. (1983). Hispanic cultural influences on medical practice. *Journal of National Medical Association, 75*(10), 941-946. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2561612/pdf/jnma00233-0029.pdf

Sánchez, J. P., Poll-Hunter, N. I., Acosta, D. (2015). Advancing the Latino physician workforce-population trends, persistent challenges, and new directions. *Journal of the Association of American Medical Colleges, 90*(7), 849-853. doi: 10.1097/ACM.0000000000000618

Schwei, R. J., Guerrero, N., Small, A. L., & Jacobs, E. A. (2019). Physician perceptions of the types of roles interpreters play in limited English proficient pediatric encounters and how they evaluate the quality of interpretation. *Primary Health Care Research & Development*, *20*(25). doi:10.1017/S1463423618000890

Sheppard, V. B., Williams, K. P., Wang, J., Shavers, V., Mandelblatt, J. S. (2014). An examination of factors associated with healthcare discrimination in Latina immigrants: the role of healthcare relationships and language. J*ournal of the National Medical Association, 106*, 15-22. doi: 10.1016/S0027-9684(15)30066-3

Steinberg, E. M., Valenzuela-Araujo, D., Zickafoose, J. S., Kieffer, E., & DeCamp, L. R. (2016). The "battle" of managing language barriers in health care. *Clinical Pediatrics*, *55*(14), 1318–1327. doi: 10.1177/0009922816629760

The Postsecondary National Policy Institute. (2020). Latino students. *Fact Sheets.* https://pnpi.org/latino-students/

United States Census Bureau. (2018). Hispanic heritage month 2018. *Facts for Feature.* https://www.census.gov/newsroom/facts-for-features/2018/hispanic-heritage-month.html#:~:text=The%20Hispanic%20population%20of%20the,of%20the%20nation's%20total%20population.

United States Department of Health and Human Services. (2016). Nondiscrimination in health programs and activities: final rule. *Federal Register, 81*(96), 31375-31473. https://www.govinfo.gov/content/pkg/FR-2016-05-18/pdf/2016-11458.pdf

Wu, A. C., Leventhal, J. M., Ortiz, J., Gonzalez, E. E., Forsyth, B. (2006). The interpreter as cultural educator of residents: improving communication for Latino parents. *Archives of Pediatrics and Adolescent Medicine, 160*(11), 1145-1150. doi: 10.1001/archpedi.160.11.1145

Yawman, D., McIntosh, S., Fernandez, D., Auinger, P., Allan, M., Weitzman, M. (2006). The use of Spanish by medical students and residents at one university hospital. *Academic Medicine, 81*(5), 468-473. doi: 10.1097/01.ACM.0000222280.05953.19