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Looking Beyond Patient Satisfaction: Experiences of Spanish-Speaking Patients Seeking Non-Urgent Care in an Emergency Department

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Looking Beyond Patient Satisfaction: Experiences of Spanish-Speaking Patients Seeking Non-Urgent Care in an Emergency Department

by

Seiichi Villalona

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
with a concentration in Applied Medical Anthropology
Department of Anthropology
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ABSTRACT

This exploratory mixed-methods study examines the experiences of Spanish-speaking patients seeking non-urgent care in an emergency department setting. Emphasis is placed on understanding variables that influence patient satisfaction among this particular special patient population. This study draws from the explanatory models of illness and perspectives of clinically applied anthropology in contributing to the limited body of scholarly work that utilizes ethnographic approaches in clinical spaces to investigate how patients experience seeking emergency care services. Health-related deservingness, social determinants of health, and health literacy are used as complementary frameworks in understanding the unique experiences of these patients. The combination of methodological approaches employed in this study included: participant observation (120+ hours), patient shadowing (40 hours, N=10), administration of a modified patient satisfaction survey (N=100), semi-structured interviews (N=25), and retrospective analysis of existing patient satisfaction data from the research site. Quantitative findings generally indicate high degrees of satisfaction among this particular patient population, with statistically significant differences when compared to English-speaking patients. Quantitative data also indicate how modality of communication with this patient population is important to consider in terms of patient comprehension and perceived levels of care/attention demonstrated by hospital staff. The qualitative findings from this project highlight the similarities in explanatory models of illness between this patient population and emergency medical providers. Qualitative data additionally elucidates many of the barriers Spanish-speaking

patients face when seeking out non-urgent care such as: limitations in exercising individual autonomy when communicating with medical staff, self-blame for not being able to effectively articulate their symptoms and concerns, as well as lack of clarity in understanding follow-up care plans. The results from this study call for addressing issues pertaining to health literacy, specifically at the end of the clinical encounter when follow-up care and treatment plans are explained to patients.

CHAPTER 1: INTRODUCTION

“Well, it would be nice to understand what they are saying, but one has to be thankful for any kind of medical attention they give us.”¹ These were the words of Marcos (pseudonym), a 31 year–old Mexican farmworker in the strawberry fields of Plant City, Florida. When I met Marcos, he was a patient presenting to the emergency department (ED) for a work-related injury to his knee that had progressively worsened after three weeks of not seeking medical care. His present condition was a collective product of several factors. First, Marcos was undocumented and uninsured, limiting the clinical spaces where he could go to in order to have his knee medically evaluated. Second, his financial situation forced him to work six days a week in order to pay for his portion of the monthly rent and living expenses in the apartment he shared with his two cousins; this exacerbated the injury and gave it no time to heal. Third, Marcos had no access to a reliable form of transportation, which also contributed to not getting his knee evaluated in time. While these factors synchronously exacerbated his condition, Marcos also faced frustrations with being unable to fully communicate with the medical staff overseeing his care in the ED. These frustrations stemmed from difficulties describing the events that led to his sustained injury, how his pain reached the point of not being able to walk properly, as well as what measures he took as an outpatient to treat his condition. Although these details may appear seemingly benign in a clinical setting structured to respond to time-sensitive health conditions, the ability to communicate effectively with medical staff and comprehend their explanations or instructions on

¹ “*Pues sería chido poder entender lo que están diciendo, pero uno tiene que agradecer cualquier tipo de atención médica que nos den*”

follow-up are important for the continuity of care as well as the overall long-term health outcomes for patients who do not speak English as a first language (Karlner et al. 2010, Divi et al. 2007, John-Baptiste et al. 2004, Timmins 2002, Derose and Baker 2000).

I asked Marcos to describe his experiences communicating with the medical staff during his stay in the ED, to which he responded: "Of course you get frustrated. But it's not their fault that they do not understand us, we should understand them. I know they do the best they can, although it's really hard for me to understand them".² This complex sense of frustration, empathy, and self-blame encapsulated a situation that in many aspects was out of Marcos' direct control. During my time studying the ED as an ethnographer, I soon came to realize that Marcos' story and views about receiving medical attention were not a special case, but actually a fairly common and daily experience among patients that do not speak English as a first language when they seek non-urgent healthcare services in emergency medical settings.

Framing the Issue: Language and Emergency Care

According to the Pew Research Center, the Latino population has led the demographic growth in the United States since 2000 (Krogstad and Lopez 2014), representing half of the total population growth in the country. These demographic shifts are influenced by factors such as immigration and the establishment of transnational communities, which have altered the ethnic composition and cultural landscapes of urban populations. Up until 2016, Latinos were considered to be the largest and fastest growing racial minority in the United States (Lopez, Gonzalez-Barrera, and López 2017). This diverse population encompasses a wide variety of ethnic backgrounds, countries of origin, citizenship and legal status, as well as English language

² *"Por supuesto uno se frustra, pero no es su culpa que no nos entiendan. Nosotros deberíamos de entenderlos. Yo se que ellos hacen lo mejor que puedan, aunque de veras se me hace difícil entenderlos"*

proficiency. Demographic studies consistently suggest that Spanish is the most spoken non-English language, and is the primary language used to communicate among foreign-born immigrants (60%) and individuals older than 30 years of age (Gonzalez-Barrera and Lopez 2013). Despite sharing a common language, unique differences exist between Spanish dialects and how the language is used.

Language has been a point of interest in scholarly examinations within other forms of anthropological inquiry including medical anthropology (Brown et al. 2009). Language serves as a crucial tool during times of illness, especially when considering that communication dictates the interactions between patients and medical providers, the degrees of mutual understanding between both parties, and how the management of medical conditions is negotiated. Another component in this equation is the sociocultural influences that shape the explanatory models of both patients and providers, which interface within the clinical settings. Physician-patient discordances in explanatory models raise barriers during the clinical encounter, the development of follow-up care plans, and continued adherence to medical treatments for the management of chronic health conditions (Derose and Baker 2000, Carrasquillo et al. 1999, Gany and de Bocanegra Thiel 1996). The combination of language barriers and discordant explanatory models presents a formidable challenge for healthcare institutions and physicians seeking to meet the needs of special patient populations, which often are predominantly comprised of patients who do not speak English as a first language. Despite impacting most parts of the U.S. healthcare system, the ED is one clinical setting where this issue is particularly salient, significantly pronounced. Distinct from the other clinical settings within the U.S. healthcare system, EDs constitute a physical space where time-sensitive health conditions are treated and managed with limited to no time for preparation, often with life or death consequences.

Emergency medicine (EM) is one of the newest medical specialties, originally stemming from the lack of specialized treatment for time-sensitive medical conditions (Zink 2006). Since its establishment as a distinct profession, EM has evolved to become one of the first access points to healthcare services for urgent and non-urgent conditions, and, in the US, is often a primary point of care for uninsured and underinsured populations (Hock et al. 2005). Latinos comprise a significant proportion of the patient populations that are seen in EDs (Sandoval et al. 2010, Flores and Ngui 2006), which sets the stage for stressful, emotionally heightened, and possibly contentious interactions between overworked ED staff and non-English speaking patients. The stressful nature of the ED setting is magnified when considering the public health and administrative healthcare concern of hospital overcrowding, which is partially attributed to non-urgent ED use (Allen and Cummings 2016), accounting for about 30% of the 116.8 million ED visits completed annually (Uscher-Pines et al. 2013, Niska, Bhuiya, and Xu 2010). Here, non-urgent ED use is defined as clinical encounters that do not require immediate medical attention (such as active resuscitation for cardiac conditions), could have been safely delayed up to 24 hours for evaluation of symptoms, or could have been treated in an outpatient setting (Allen and Cummings 2016, Agency for Healthcare Research and Quality 2015, Subcommittee on Primary Health and Aging 2011, Weinick, Burns, and Mehrotra 2010, Niska, Bhuiya, and Xu 2010). The issue of overcrowding and non-urgent ED use has reached the attention of national organizations such as the United State Senate's Subcommittee on Primary Health and Aging as well as the Agency for Healthcare Research and Quality, which have established the reduction of non-urgent ED visits as one of their priorities (Allen and Cummings 2016). Some studies point to the negative impacts of the combined effects of ED overcrowding and non-urgent ED use on increased costs, pain and suffering, longer wait times, and missed opportunities to connect

patients needing follow-up care with primary care providers in outpatient and community settings (Allen and Cummings 2016, Uscher-Pines et al. 2013, Weinick, Burns, and Mehrotra 2010, Warden et al. 2006, Derlet and Richards 2000). While there is considerable dialogue between researchers, healthcare practitioners, and policymakers regarding the burden of overcrowding and frequencies of non-urgent ED use among Hispanic/Latino populations (Villani and Mortensen 2013, 2014, Chavez 2012, LaCalle and Rabin 2010, Hong, Baumann, and Boudreaux 2007, Cunningham et al. 1995), few studies have ethnographically examined the patient perspective when these populations actually seek care in EDs. Even fewer have conducted research in a clinical setting, relying instead on retrospective interviews. The continually evolving nature of EM and daily interface between Spanish-speaking patient populations with medical professionals in EDs collectively serve as a backdrop in recognizing this clinical space as a unique ethnographic setting where explanatory models are constantly negotiated.

Study Objective, Aims, and Research Questions

This exploratory, mixed-methods ethnographic study addresses the issues of communication, medical translation, and interpretation between emergency medical professionals and patient populations that do not speak English as a first language. The objective of this project was to draw from anthropological methods and theories to understand the experiences of Spanish-speaking patients as well as offer medical and administrative staff insights on important factors to consider when providing care to this unique patient population. This study aimed to answer the following research questions:

1. What are the experiences of Spanish-speaking patients seeking non-urgent medical evaluation in an emergency medical setting?
2. How do factors such as explanatory models, language, and culture impact patient satisfaction, comprehension, and the overall experience of receiving medical care in an ED?
3. How do these aforementioned factors impact the overall clinical encounter, interactions, and communication between this special patient population and medical professionals that oversee their care?
4. How does modality of communication (whether it be bilingual medical staff, bilingual non-medical staff, or available translation services) impact satisfaction, understandings, and the overall experience of receiving care among Spanish-speaking patients?

Expected Research Findings

Several hypotheses were proposed throughout the development of the guiding research questions and prior to the start of data collection. The hypothesis proposed for the first guiding research question was that Spanish-speaking patients experience seeking non-urgent ED care in a unique and nuanced way than other patient populations. It was additionally expected for this specific patient population to use explanatory models of illness that contrast the models of the medical team overseeing their care. This expectation stemmed from the understanding of this patient population to be comprised of multiple ethnic backgrounds with perspectives on health and illness that may not be universal across cultural groups and may significantly differ from the Western biomedical model of disease. Keeping this in mind, it was hypothesized for these contrasting explanatory models of Spanish-speaking patients to negatively impact overall patient

satisfaction and comprehension. In this same vein, it was expected for language discordances between these patients and the medical team to further contribute toward negative perceptions of the overall ED care provided. These hypotheses are informed by previous work that suggest the potential link between physician-patient discordances in explanatory models and language to more negative experiences throughout the clinical encounter, follow-up care, and overall health outcomes (Flores et al. 2012, Cabassa et al. 2008, Flores 2005, Betancourt, Carrillo, and Green 1999). Lastly, it was hypothesized that technology-based translation services would be associated with higher levels of satisfaction and overall comprehension in comparison to instances when family members, bilingual members of medical team, or ancillary staff provided translation. This expected finding is informed from previous technology-based translation/interpretation studies with Spanish-speaking patients in clinical settings (Gany, Kapelusznik, et al. 2007, Gany, Leng, et al. 2007, Lee et al. 2002).

Overview of Chapters

This thesis presents the results from research conducted between March 2017 and November 2017 and concludes with considerations for providing medical care to Spanish-speaking patients in emergency medical settings. Chapter Two provides an in-depth literature review that situates this study's contribution to both medical anthropology and EM. This chapter begins with a section devoted to the histories of EM and "quality movement" in the US healthcare system. Tracing the EM's origins and development through the profession's contemporary practice is important in contextualizing and examining EDs as unique clinical sites to conduct ethnographic work. Understanding the rise of the "quality movement" in the US healthcare system offers applied interdisciplinary researchers insights on how to approach new projects in clinical settings,

and more importantly, how to inter-professionally translate research findings to align with the current concerns of partnering medical practitioners and healthcare administrators. The following section discusses previous works that address health, language-related issues among Spanish-speaking patient populations, and patient satisfaction. Here, I draw from social scientific and medical literature with a specific focus on reviewing scholarly work conducted in clinical settings. This chapter concludes with a review of the guiding theoretical frameworks, namely, explanatory models of illness and clinically applied anthropology within the larger discipline of medical anthropology and the complementary concepts of health-related deservingness, health literacy, and language as a social determinant of health. This final section situates how these frameworks and conceptual approaches informed the design, methodology, and analyses of this study. Chapter Three contextualizes the clinical site where this study was conducted. This chapter presents background information on the region, county, and partnering healthcare institution. Chapter Four outlines the methodology employed in this study and the approaches used for data analyses. Ethical considerations for conducting ethnographic work in a clinical setting are discussed in relation to research design and working with special patient populations. Chapter Five presents the qualitative and quantitative research findings from all three phases of the study. Chapter Six discusses the analyses of the results, drawing from the guiding theoretical frameworks outlined in Chapter Two. A section in this chapter is specifically dedicated to discussing important ethical considerations in generally conducting ethnographic work in clinical settings with a specific emphasis on the role(s) and positionality of the researcher throughout data collection, analysis, and dissemination of findings. Finally, I offer insights to consider for emergency medical practice as well as points of departure for future work with Spanish-speaking patients in emergency care settings.

CHAPTER 2: LITERATURE REVIEW

In order ethnographically study the experiences of Spanish-speaking patients seeking healthcare services in emergency care settings, it is important to contextualize this topic and outline key theoretical frameworks to guide the methodological and analytical approaches to this work. This chapter begins with two key histories that first trace the origins of emergency medicine (EM) as a profession and its evolution into contemporary times, followed by a history on the rise of the quality movement in U.S. healthcare. Both of these histories are important in understanding the social forces and factors that led to healthcare's current state in terms of clinical practice, dominant paradigms, research priorities, and future directions of the profession. These histories also help identify how some of the sociocultural factors that originally influenced EM's evolution continue to persist today as well as elucidate some of the new forces that are currently driving the profession's development. Recognizing these trends establishes a way of addressing some of the challenges emergency departments (EDs) face on a daily basis through the use of applied research findings.

Among the social sciences, medical anthropology is well suited to address many of the issues impacting the U.S. healthcare system. This utility stems from the discipline's toolkit of conceptual frameworks, methodologies, analytical approaches, and most importantly, the ability of applied anthropologists to translate research findings into practical uses with(in) communities and collaborating institutions. The second section of this chapter presents the body of scholarly works in the social and biomedical sciences with Spanish-speaking patients, with a specific focus

on work done in EM. Reviewing this topic within both disciplines allows for an examination of where research interests contrast or directly align through different sets of priorities (theoretical versus practical).

The final section in this chapter outlines the theoretical frameworks that informed the design of this study, its methods, and analytical approaches. Here I discuss how medical anthropology, specifically drawing from the explanatory models of illness framework and clinically applied anthropology, is well suited in examining an ED and how Spanish-speaking patients come to make sense of the care they receive. Considering that language is a key variable to this study, I then provide an overview on social determinants of health in order to frame how language plays an important role in the overall health outcomes of patients, and is even more crucial among non-English speaking patient populations. This chapter concludes with a review of *deservingness* and health literacy as two useful concepts in respectively studying how Spanish-speaking patients perceive the care they receive and understand their conditions as well as their follow-up care plan. These two concepts are central in developing interventions (whether they be administrative, educational, or clinical) that can be tailored to the needs of Spanish-speaking patients seeking non-critical services in emergency care settings.

Brief Histories

A Genealogy of Emergency Medicine

The historical contexts and societal trends that fueled EM's evolution as a distinct medical subspecialty must be understood in order to theoretically situate EDs as a unique clinical site for ethnographic work. The origins of EM trace back to the early 1960s in Alexandria, Virginia

where the first ED was created in a small community hospital as a way of providing twenty-four hour acute care to urban communities (Merritt 2012, Zink 2006). This arose from the large influx of the general American population into major cities across the nation. As a result, the general population increasingly turned to hospitals when seeking primary healthcare services, a shift away from the reliance on community-based physicians that performed house calls and treated patients in their own homes (Merritt 2012). The post-WWII era of the 1950s is a crucial historical factor to take into consideration in explaining 1) the large-scale societal shift that concentrated patients in cities and 2) the technological advances that drove the advancement of American medicine (Zink 2006). This time period was marked by a boom of industries in major cities as well as by the development of the national highway system, which played a significant role in increasing the mobility of families that were previously rooted within their hometowns. This time period was also characterized by global society being at the edge of modernity, where innovations in medicine and science rapidly grew and changed the types of technologies used in clinical practice. This technological boom in American biomedicine influenced the substantial decrease in physicians who performed house calls, since many of these new diagnostic technologies were not practically mobile (Zink 2006). These trends led to the concentration of biomedical technologies within the institutional walls of hospitals. Collectively, these societal and historical influences of the 1950s created the groundwork for the establishment of the first ED. The evolution of the profession however, was heavily influenced by other political, social, and structural changes that occurred during the mid and late 1960s.

Although the societal shifts in the 1950s began creating the backdrop to the rise of EM as a distinct profession, no formal structure for EM clinical practice would be established until the early 1960s. As previously noted, increased mobility resulted in fewer families continuing to

regularly see their family doctor and turning to hospitals for medical evaluation whenever they became sick (Merritt 2012). This eventually gave rise to the “Alexandria Plan,” developed by James Mills and two other colleagues, which established that patients who did not have a private primary care physician overseeing their medical care were to be treated by emergency doctors in hospitals (Zink 2006, Edlich 1991). Another important milestone for the formalization of EM was the type of medical staff that worked early emergency rooms, which initially consisted of nurses and recent medical school graduates interning as first year physician residents. The idea behind having these physician residents run early emergency rooms starting in their first year resulted from an institutional agenda in American medicine of offering physicians-in-training with rigorous learning opportunities. While this unique medical setting provided educational opportunities, it also left the lives of patients in the most critical need of care in the hands of the least prepared physicians (Zink 2006). This realization incited the second wave of efforts by a group of physicians in formalizing EM as a practice, culminating in the creation of the “Pontiac Plan” of the 1960s. This plan outlined the practice of having licensed doctors rotate in hospital emergency rooms to work as attending physicians, manage the treatment plans of patients, and supervise the staffed resident physicians (Zink 2006, Krome 1997). This institutional strategy exposed other problems regarding urgent patient care, since the specializations of attending physicians such as dermatology or podiatry were not adequate in managing some of the time-sensitive cases such as myocardial infarctions or appendicitis. The absence of specialized emergency training in medicine became especially evident with the wave of trauma cases that resulted from the violent riots occurring in latter half of the 1960s, during the height of the African-American civil rights movements (Shoemaker et al. 1993, Fleming et al. 1992, Fogelson 1970). The lack of formal emergency medical education, universal protocols, and training was as

a major critique and contention of the new specialty from other established medical professions. The establishment of the American Board of Emergency Medicine and official professional accreditation did not occur until 1979, after nearly a decade of debates between physicians over the legitimacy of EM having a unique body of knowledge (Suter 2012, Zink 2006).

These periods of societal changes and institutional challenges unique to EM continued into the 1980s, which were characterized by increases in “patient dumping” incidents. This occurred when private hospitals transferred minority and/or indigent patients to public hospitals after hurriedly stabilizing them, regardless of whether more complex care was required (Curran 1997). This was an administrative scheme for private hospitals to reduce the incurring of costs from poor or uninsured patient populations (Curran 1997, Enfield and Sklar 1987). “Patient dumping” further materialized the public-private divide of hospitals and two-tier healthcare delivery system, where private hospitals prioritized treating wealthy and adequately insured patients (Enfield and Sklar 1987). This resulted in public hospitals (which were often understaffed, underfunded, and with limited resources) fully bearing the responsibility of treating medically indigent populations (Enfield and Sklar 1987). The rise of violent crimes to epidemic proportions during the 1980s (Centers for Disease Control and Prevention 2016), especially among minority and indigent populations (US Department of Health and Human Services 1985), produced considerable stress on the overall infrastructure of US healthcare. This stress was magnified on EM, which functioned as the gateway to the American healthcare system.

“Patient dumping” practices and infrastructural stress on public hospitals were the major impetus in passing the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA). This federal law emerged as an “anti-dumping” policy that required Medicare-participating hospitals with EDs to triage, treat, and stabilize the emergency medical conditions of patients in

a non-discriminatory manner to anyone, regardless of their ability to pay or insurance status (Centers for Medicare and Medicaid Services 2012). EMTALA represented a direct response from emergency physicians employed at public hospitals advocating against the callous practices of private hospitals in clinically neglecting indigent populations and consequently overloading public hospitals (Curran 1997, Enfield and Sklar 1987). This was one of the policies passed by Congress in reorganizing the structure of healthcare, specifically EM, to better address the needs of urban communities. Another example of a policy that continued to transform EM was proposed by the National Academy of Sciences Institute of Medicine in 2000, which forced EDs to adopt an open-door policy that serve the needs of patients that enter their facilities throughout all hours of the day (Hock et al. 2005). This policy addressed disparities in seeking emergency medical evaluation that was not temporally fixed to the typical 9AM-5PM work hours and allowed for these services to be available at any time of the day. These examples offer a brief contextual snapshot on the evolution of EM as the “safety net” and gateway of the American healthcare system that continue to be key characteristics of the profession as it is practiced today (Hock et al. 2005).

Lasting Legacies and Constant Change

An understanding of the historical contexts and societal forces that gave rise to EM delineates the revolutionary roots of this medical subspecialty. The evolution and re-evolving of the profession is crucial in examining how contemporary societal issues are affecting the US healthcare system. EM began at the junction of multiple societal changes during the post-war eras of the 1950s, developed throughout the 1960s, formalized in the late 1970s, and being directly implicated in the passing of government policies geared to meet the needs of diverse

communities and patient populations. Tracing the genealogy of EM as a profession allows for the recognition of this clinical site as being one of the very first spaces within the American healthcare system where societal issues manifest. Much like the very nature of the clinical practice of EM is uncertain, the profession as a whole is subject to constant change that is distinct to other medical specialties (Merritt 2012). Serving as the “linchpin” for multiple systems of care, contemporary EM functions to connect patients of a wide array of different medical conditions with appropriate providers of primary, specialty, inpatient, outpatient and community-based care (Rhodes and Pollock 2006). EM secondarily functions in identifying some of the unmet health needs of special patient populations affected by major sociocultural problems that directly impact individual health outcomes and the greater public health of communities serviced by EDs (Rhodes and Pollock 2006).

Quality Healthcare and Patient Satisfaction

The development of the quality movement in American healthcare and subsequent increased interest in patient satisfaction are two other important concepts needed to historically contextualize how the patient experience can be ethnographically studied in EDs. The quality movement can be traced back to the mid-1970s (Press 1997), during a time period that came to be known as the first “malpractice crisis” (Thorpe 2004, Robinson 1986). The referencing of this time period as a crisis stemmed from the threefold effects of 1) increased number of malpractice claims, 2) sharply rising premiums for practicing physicians and healthcare institutions, and lastly, 3) the withdrawal of a majority of insurers due to investment losses and uncertain profits (Thorpe 2004, Robinson 1986). In light of this changing legal and economic landscape, healthcare institutions responded to the crisis by instituting quality assurance and risk

management programs as a way of preventing and minimizing errors during medical care as well as malpractice suits. These programs consisted of protocols, standardized procedures, and other quality control efforts.

Although there was some acknowledgement among healthcare administrators and physicians about the utility of culturally-sensitive patient interactions in risk prevention by the 1980s (Press 1984), general concern for the perspectives of patients was not considered a serious issue up until hospital revenues began to dramatically be reduced (Press 1997). This decade saw the creation of two key structural elements of how hospitals operate as a business. First, the diagnosis-related group (DRG) system was introduced as a way of classifying the resources that healthcare institutions used when treating different types of medical conditions. This was used for reimbursement in place of "cost based" compensation that had been used up to that point and had created large financial stresses on healthcare's infrastructure. The introduction of DRGs essentially limited Medicare reimbursements and forced hospitals to reassess how resources were utilized in providing healthcare services. With this new system less became more, more money at least. This is to say that the introduction of the DRG system shifted clinical practice from a model where physicians employed all possible diagnostic methods in evaluating patient symptoms (regardless of cost), towards an approach where fewer resources were utilized that still accomplished the same types of clinical assessments. The second important structural change that occurred during the 1980s was the creation of the prospective payment system (PPS), which was introduced as a method of Medicare reimbursement based on a predetermined, fixed amount (Press 1997). This was closely associated with the creation of the diagnosis-related group (DRG) system. Both of these new structural elements in healthcare expenditure came after the introduction of health maintenance organizations (HMOs) in the 1970s, medical insurance

groups that offer managed care for health insurance, self-funded healthcare benefit plans, individuals, and corporations that provided their employees with health coverage plans, among others, by serving as a bridge between those covered and healthcare providers (Dorsey 1975).

The structural changes to healthcare management and reimbursement in the 1970s and 1980s collectively began to financially impact hospitals, resulting in decreases of revenues and competition for filling beds with “customers” while still bearing in mind risk prevention strategies (Press 1997). As a result, hospitals began to implement guest relations programs and hire patient representatives in efforts to offer satisfactory care to the patient populations they serviced. This movement drew from the marketing and the hotel industries as a first attempt by healthcare institutions to formalize concern for the interpersonal aspects of clinical care (Press 1997). During this time period, the philosophy of “total quality management” (TQM) was quickly spreading in American industry as a way of product and process improvement, which would later become adopted by hospitals in 1987 (Press 1997). This adoption of TQM and its derivative after successful implementation, “continuous quality improvement” (CQI), came after the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) made both of these practices guiding principles of their “Agenda for Change” (Press 1997). Here, the JCAHO revised the standards for hospital accreditation in light of the wave of criticisms regarding the low quality of care and “grade inflation” in hospital reviews throughout the mid-1980s (Press 1997). The trajectory of the quality movement is important because it elucidates to the growing institutional concern at that time for hospitals to change their approaches and infrastructure in order to meet the needs of the growing demand for quality healthcare services. Stepping back, one is able to recognize that incorporation of TQM and CQI principles into healthcare

management had a pronounced effect in changing the organizational culture of hospitals across the country (Press 1997).

The adoption of TQM and CQI principles by healthcare institutions did not directly translate into changes immediately, since hospitals struggled at studying and operationalizing patient satisfaction. A new market in administrative healthcare research began when medical anthropologist, Irwin Press, and sociologist-statistician Rod Ganey founded Press Ganey Associates in 1985 (Siegrist Jr 2013). Press and Ganey respectively combined their expertise in anthropologically understanding the sociocultural and clinical needs of patients that could improve care and the reduction of claims (Press 1985, 1984) with rigorous survey methodology, to introduce the science of survey design, administration, and evaluation to healthcare TQM and CQI initiatives (Siegrist Jr 2013). Starting with only a handful of hospital clients, Press Ganey Associates exponentially grew their client base over the decades that followed after hospitals began seeing the value of measuring and tracking patient satisfaction as well as comparing these values to similar healthcare entities (Siegrist Jr 2013). Over the next few years, the number of companies that provided consulting services for patient satisfaction grew along with the clinical sites where these evaluations were conducted including: inpatient units, emergency departments, outpatient clinics, and ambulatory surgery among others (Siegrist Jr 2013). The quality healthcare movement and increased attention on patient satisfaction became even more pronounced after the Institute of Medicine's publication of *To Err is Human* in 2000. This publication further added to this movement by addressing the issue of patient safety and beginning to challenge the concept of fee-for-service reimbursement model in light of poor population health outcomes and high rates of medical errors, with sometimes deadly consequences.

It was not until 2002 that the federal government first became engaged with patient satisfaction when the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) jointly studied, developed, and tested the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey (Center for Medicare and Medicaid Services 2016, Siegrist Jr 2013). This survey included 27 questions that assess the experiences of patients during their hospital stay with regards to the following topics: communication and responsiveness of hospital staff, cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information, and overall rating of hospital (Center for Medicare and Medicaid Services 2016). The multi-step process used to design the HCAHPS survey included a public call for quality measures for certain medical conditions, multiple *Federal Register* notices requesting public comments on the draft survey before initiating the pilot study, a review of the relevant literature, meetings with hospitals, consumers and survey vendors, as well as cognitive interviews with consumer (Goldstein et al. 2005). The process was followed by piloting the HCAHPS survey among 49,812 medical and surgical patients in New York, Arizona, and Maryland (Goldstein et al. 2005), ultimately being endorsed by the Hospital Quality Alliance and the National Quality Forum in October 2005. The HCAHPS survey was nationally implemented in October 2006 (Siegrist Jr 2013) and was implicated in the Deficit Reduction Act of 2005 that included legal statutes offering hospitals financial incentives for participating in HCAHPS reporting starting in 2007 (Center for Medicare and Medicaid Services 2016). By 2008, the HCAHPS survey quickly gained support and became directly tied to the Annual Payment Update (APU) for hospitals participating in the Inpatient Prospective Payment System (IPPS) (Giordano et al. 2010). This statute required general acute care hospitals reimbursed through the IPPS to collect and publicly

report HCAHPS results to receive their full APU (Giordano et al. 2010). Hospitals reimbursed through the IIPS that failed to report their required quality measure could have been subject to an APU reduction by two percent as part of the CMS' *Reporting Hospital Quality Data for Annual Payment Update* (RHQDAPU) program (Giordano et al. 2010).

The transformation in the quality healthcare and patient satisfaction industry from voluntary involvement by certain local hospitals partnering with independent consulting vendors to the national implementation of the HCAHPS survey and the direct linkage to APUs drove about 95% of hospitals in the country to “participate” in the public reporting of quality measures (Center for Medicare and Medicaid Services 2016, Giordano et al. 2010, Siegrist Jr 2013). The financial incentives through the Deficit Reduction Act of 2005 and the RHQDAPU program were further reinforced through the Affordable Care Act of 2010 that outlined hospital reimbursements to be directly influenced by comparative performance between healthcare institutions and improvements of HCAHPS survey measures (Center for Medicare and Medicaid Services 2016, Siegrist Jr 2013).

Tracing the origins and rise of the quality movement and interest in patient satisfaction offers an integral understanding of healthcare's current state. Doing so additionally provides an understanding on the ways this movement influenced the development of EM historically and its characteristics in the present day. An important lesson elucidated from historically examining the quality movement is the close association in the ideals of consumerism, business, marketing, and finances to the types of social interventions being implemented in order to improve patient satisfaction. This background highlights the limited engagement from applied social scientists in collaborating with healthcare institutions to research and broadly address issues regarding quality and satisfactory care. This background additionally

points to the timeliness of applied research of healthcare quality, patient satisfaction, and the patient experience in institutional clinical settings. This section's discussion of quality and satisfaction will be central to the results and analyses of this study as they raise new considerations in approaching the special needs of Spanish-speaking patient populations that seek healthcare services in EDs.

Anthropology, Emergency Medicine, and Special Patient Populations

Language Barriers and Health

Broadly speaking, language barriers in healthcare have been identified as an important determinant of overall poorer health outcomes among patients that speak a different first language than their medical providers (Meuter et al. 2015). Language discrepancies between patients and providers can lead to communication errors with significant medical consequences as well as increased psychological stress for patients who are already anxious about a health condition or set of symptoms (Bowen 2001). Effective patient-provider communication is particularly important in explaining the potential causes of a patient's present condition, details of a diagnosis, treatment options, and potential risk factors of all possible courses of action (Meuter et al. 2015, Schenker et al. 2007, Gillotti, Thompson, and McNeilis 2002). Barriers to effective communication can lead to misunderstandings of follow-up care instructions, adherence to treatment, and ultimately contribute to continued poorer health outcomes among linguistic minority patients (Meuter et al. 2015, Flores 2005, Timmins 2002). Understanding the importance of language throughout the clinical encounter contextualizes how patients with

limited English proficiency experience seek non-urgent care as well as how language influences their understandings of their follow-up care plan.

Spanish-Speaking Patient Populations and Biomedical Research

Medical and public health literature that has studied Spanish-speaking patient populations in emergency care settings has largely examined the issues pertaining to 1) non-urgent ED use and the factors influencing these health seeking behaviors (Allen and Cummings 2016, Berry et al. 2008, Hong, Baumann, and Boudreaux 2007, Nandi et al. 2008, Doty and Holmgren 2006, Carrillo et al. 2001, Derose and Baker 2000), 2) consequences of physician-patient language discordances (Steinberg et al. 2016, López-Cevallos, Harvey, and Warren 2014, Perez, Sribney, and Rodriguez 2009, Sarver and Baker 2000, David and Rhee 1998, Woloshin et al. 1995, Kirkman-Liff and Mondragón 1991), as well as 3) assessments of effectiveness and costs of linguistic interventions in clinical settings (Schenker et al. 2011, Crossman et al. 2010, Jacobs, Sadowski, and Rathouz 2007, Karliner et al. 2007, Jacobs et al. 2004, Fagan et al. 2003, Jones 2008, Bernstein et al. 2002, Paras et al. 2002, Baker, Hayes, and Fortier 1998, Ginsberg et al. 1995). One consensus in the literature is the recognition on the importance of language throughout the clinical encounter between patients and medical professionals. This existing body research with Spanish-speaking patients has heavily focused on two distinct areas: the improvement of patient satisfaction scores (Bagchi et al. 2011, Ngui and Flores 2006, Halfon et al. 2004, Garcia et al. 2004, Lee et al. 2002, Carrasquillo et al. 1999, Betz Brown et al. 1999, Kuo and Fagan 1999, Baker, Hayes, and Fortier 1998) and determining best practices to physician-patient communication through controlled trial studies (Lion et al. 2015, Jacobs, Fu, and Rathouz 2012, Flores et al. 2012, Crossman et al. 2010, Locatis et al. 2010, Diamond and

Reuland 2009, Diamond et al. 2009, Gany, Kapelusznik, et al. 2007, Gany, Leng, et al. 2007, Brach, Fraser, and Paez 2005, Flores 2005, Garcia et al. 2004). Despite multiple medical translation and interpretation studies, no distinct modality has consistently stood out as an evidenced-based best practice in terms of communicating with Spanish-speaking patients. These studies range in the types of methodologies used, which include self-administered surveys/questionnaires, patient interviews, as well as video recordings, and have predominantly employed quantitative analyses in developing conclusions and positing where to continue research with Spanish-speaking patients.

To date, research with this patient population in emergency care settings has advanced understandings of some of the unique needs of patients with limited English-language proficiency as well as the factors involved in seeking non-urgent care in EDs. Despite this progress, these same approaches come with limitations in their analytical scope and have left gaps in the literature of understanding how Spanish-speaking patients experience healthcare in an ED. Primarily using quantitative measures overlooks the variability in situational contexts (such as socioeconomic status, legal status, cultural beliefs of health, etc.) of participating patients that influence their health seeking behaviors. This is to say that quantitative analyses do not lend themselves to offering important context-dependent information that can either influence patient comprehensions of follow-up care or even reinforce repeated non-urgent ED use among this patient population. In a study of limited English proficiency and usage of physician services among Hispanic/Latino patients, Derose and Baker (2000) discuss several of the complex social factors that could influence poor health outcomes among this patient population while additionally pointing out that the local health care environment, such as distribution and availability of free clinics and outpatient health centers, could be another key aspect to consider.

A similar discussion is presented by Chan and colleagues (2010) in their review of interpreter services within emergency medicine, where they acknowledge that solutions to servicing the needs of patients who do not speak English as first language will ultimately vary depending on the population of patients served and availability of resources to individual hospitals. Both of these studies highlight the potential of ethnographically studying EDs and the special patient populations that interact with this part of the healthcare system on a regular basis.

Another gap in the literature has been the pronounced focus on patient satisfaction and determination of universally applicable best practices. While both of these research goals are important, focusing on either again disregards some of the important context dependent factors that influence patient experiences and overlooks some of the difficulties in cross-cultural research with Spanish-speaking patients that call for specific types of methodological approaches. For example, the concept of patient satisfaction implies the idea of choice, which among certain patient populations is trivial due to fact that the ED may be one of their only options in receiving healthcare services. Using patient satisfaction as a point of investigation among certain patient populations and predominantly using quantitative analyses may not reveal other findings that could improve issues salient among Spanish-speaking patients. On one side of the spectrum, patient satisfaction has been posited to be "...associated with improved understanding of self-care and follow-up plans, reduced errors, and better treatment adherence" (Bagchi et al. 2011). On the other hand, high degrees of patient satisfaction are viewed favorably by healthcare administrators that want to increase the likelihood of patients returning to their ED to receive care as well as to reduce the chance of legal action taken by unsatisfied patients (Bagchi et al. 2011). Herein lies the triviality of strictly assessing patient satisfaction among special patient populations (such as those that do not speak English as a first language or are uninsured), since

satisfaction does not address some of the contextual issues that influence patient decisions of seeking non-urgent care in the first place. From a business standpoint, satisfied un- or under-insured patients or those who do not speak English as a first language are more costly in the long run because of the repeated use of the ED for non-urgent healthcare services. This is due to not having other options in being seen by medical professionals and/or lack of comprehension of follow-up care instructions and other available alternatives form of care. Although hospital reimbursements are partially linked to patient satisfaction scores, the most pronounced effects on hospital ratings will come from the evaluations submitted by large insured patient groups that are provided healthcare coverage through their employers rather than individual patients from surrounding communities with varying forms of insurance coverage (Press 1997).

Cross-cultural diagnostic dilemmas in EM were first discussed in *The Western Journal of Medicine* in 1980 (Weaver and Sklar 1980). The authors of this piece presented a series of cases where cultural differences functioned as a predominant factor in the diagnostic process of Western biomedicine and impacted the negotiations of therapeutic treatments between physicians and patients. While this piece highlighted some the structural inadequacies of Western biomedicine in cross-cultural contexts, recent scholarly work illustrates how the American healthcare system, especially EM, has not come a long way in the last three decades (Padela and Punekar 2009). As a result, researchers have attempted to study Spanish-speaking patient populations through the framework of cultural competency (Padela and Punekar 2009, Chan et al. 2010). Broadly speaking, the emergence of cultural competency in American medicine stemmed from the institutional concern in addressing significant health disparities among specific ethnic and racial groups (Jenks 2011, Betancourt 2003). Researchers, clinicians, and medical educators have utilized this concept to develop the argument of culture being at the epicenter of the issues

directly concerning healthcare access, doctor-patient communication, adherence to medical treatments, use of potentially harmful home remedies, and prescription practices (Hamilton and Marco 2003, Flores, Gee, and Kastner 2000, Flores 2000). Although cultural competency gained popularity within research across different medical specialties (Saha, Beach, and Cooper 2008), it was placed under scrutiny for the embedded power differentials of this concept, which implied the idea that Western biomedical professionals can “master” understandings of cultural “other” (Oelke, Thurston, and Arthur 2013, Saha, Beach, and Cooper 2008). This concept focuses on the categorical understanding of individuals from different ethnic and racial backgrounds (defined by census categories) and was argued to have strengths because of its pedagogical approach in feasibly evaluating the cultural knowledge proficiency learned by medical students, residents, and practicing physicians (Oelke, Thurston, and Arthur 2013, Campinha-Bacote 2002). The challenge of exclusively employing this framework is the disregard for intra-cultural variability and universal characterizing of individuals from the same racial or ethnic group as defined by census categories (Kumagai and Lyson 2009, Betancourt 2003). This elucidates some of the difficulties in using this concept to study Spanish-speaking patient populations in EM because of the uncertainty in this clinical setting as well as the diversity of patients regularly seen in EDs.

A more recent shift in approaches to studying Spanish-speaking patients in emergency care settings has focused on assessing health literacy, defined as the degree to which an individual has the capacity to access, interpret, as well as understand basic health information and follow-up care management (pharmaceutical, diagnostic, or referrals) to make informed decisions regarding their health (Kindig, Panzer, and Nielsen-Bohlman 2004). This approach has primarily sought to understand the factors that impact levels of health literacy among this patient population and examine how health literacy interventions can improve overall health outcomes

(Easton, Entwistle, and Williams 2010, James, Smith, and Brice 2010, Brice et al. 2008, Clark, Sleath, and Rubin 2004). This growing body of work has predominantly studied the associations of functional health literacy among Spanish-speaking patients with health outcomes (Dahl et al. 2015, Boyas 2013, Paasche-Orlow et al. 2006, Paasche-Orlow and Wolf 2008, 2010, Berkman et al. 2004) and health seeking behavior metrics such as repeated ED visits for non-urgent care and adherence to outpatient follow-up after being discharged from the ED (Samuels-Kalow, Stack, and Porter 2013, Cohen et al. 2011, James, Smith, and Brice 2010, Hohl et al. 2009, Andrusis and Brach 2007, Brice et al. 2008). Health literacy studies among Spanish-speaking patient populations have additionally begun to examine English-language proficiency, both self-reported and evaluated by validated instruments, as another predictor to poorer health outcomes (Soto Mas et al. 2013, Soto Mas et al. 2015, Sudore et al. 2009, Zun, Sadoun, and Downey 2006). Similar to the broader medical and public health literature of Spanish-speaking patient populations, this body of work predominantly employs controlled trial study designs and quantitative analyses.

Some scholars and medical practitioners have called for more rigorous qualitative approaches to studying issues in emergency medicine (Cooper and Endacott 2007). The relatively small but growing body of qualitative studies in emergency medicine was recently featured in a two-part methods series in *Academic Emergency Medicine* as a new research direction in addressing some of the social issues that manifest themselves in EDs on a daily basis (Choo et al. 2015, Ranney et al. 2015). These articles outlined the value qualitative methods and analyses offer in the studying a wide array of topics in emergency medicine, including the patient experience and special patient populations that regularly interact with EDs. To date, few researchers have specifically employed ethnographic methods in studying different patient

populations in emergency care settings. This study draws from the existing body of scholarly work from the fields of medicine and public health and contributes an anthropological perspective on understanding how language (in the linguistic and cross-cultural sense) influences patient satisfaction, health literacy, and the overall experience of receiving non-urgent care in an ED setting.

Ethnography and Emergency Medicine

Social scientific investigations within anthropology and sociology that have implicated Spanish-speaking patient populations, emergency medical care, and non-urgent use have addressed three main topical areas: healthcare access (Castañeda 2017, Brown 2008, Durden and Hummer 2006, Becker 2004, Chavez 1992, Chavez, Flores, and Lopez-Garza 1992, Chavez, Cornelius, and Jones 1986, Chavez, Cornelius, and Jones 1985, Chavez 1983), as well as healthcare policy and reform (Castañeda 2017, Hudgins and Rising 2016, Perez-Escamilla 2010, Perez-Escamilla, Garcia, and Song 2010, Ortega et al. 2007, Boehm 2005, Lamphere 2005, Becker 2004, Horton et al. 2001, Davis 1997, Brown 1990). Healthcare access of special patient populations has received considerable scholarly attention, of which include patients of color (Becker 2004, 2001, Becker and Newsom 2003), the homeless (Small 2011), the under-/un-insured (Brown 1990), and/or the undocumented (Castañeda 2017, Melo and Fleuriet 2016, Castañeda and Melo 2014, Zuckerman, Waidmann, and Lawton 2011). This body of work tackles some of the discourse surrounding special patient populations within different public, political, and professional spheres by humanizing and contextualizing the lived experiences of individuals that belong to these patient groups. As an example, the independent and collaborative work of Leo Chavez has employed a political economy approach to challenge the ideas propagated within political

discourses of undocumented Latino populations being burdens to the healthcare system due to the over utilization of emergency care services for non-urgent conditions (Chavez 2012, 1983, Chavez, Flores, and Lopez-Garza 1992) and elucidate how these groups find alternative ways to self-treat and pluralistically use formal and informal healthcare services (Chavez, Cornelius, and Jones 1986, Chavez, Cornelius, and Jones 1985, Chavez 1984). A key argument presented in this literature is the link between having insurance coverage and utilization patterns, where Latino populations that were insured tended to seek care more frequently in comparison to their uninsured counterparts who either never sought care in the United States, underutilized emergency care services, or delayed presenting to the ED until their symptoms dramatically worsened (Chavez 1992). This is an important finding in this body of work that continually emerges in consequent social scientific studies is how undocumented and uninsured patient populations in terms of prolonging seeking medical care or clinical evaluation until their conditions become more symptomatically pronounced (Castañeda 2017, Melo and Fleuriet 2016, Castañeda and Melo 2014, Becker 2004). As a result, social scientific researchers have furthered our understanding of this phenomenon through beginning to delineate how relatively chronic health conditions are exacerbated over time until they develop into more serious conditions that require specialized (and significantly more expensive) forms of care (Castañeda 2017). This more recent scholarship begins to highlight the syndemic relationship between healthcare access and chronic health exacerbations among particular patient populations.

Social scientific analyses of healthcare access among special patient populations have led researchers to discuss and critique health policy and reform during the rise of managed care in the 1990s (Horton and Lamphere 2006, Boehm 2005, Lamphere 2005, Horton et al. 2001) and, more recently, in light of the implementation of the Patient Protection and Affordable Care Act

of 2010 (Getrich et al. 2017, Mulligan and Castañeda 2017, Castañeda 2017, Dao and Mulligan 2016, Melo and Fleuriet 2016, Castañeda and Melo 2014, Horton et al. 2014). Here, the analytical lens has been placed on health “safety nets”, as a subunit of the healthcare system, to highlight some of the failings in healthcare delivery (at the local, state, and national levels) to specific patient populations and geographic regions. Scholars have defined health “safety nets” as a loose network of public hospitals, local health departments, outpatient clinics, non-profit community health organizations and individual medical practitioners (Becker 2004, Horton et al. 2001, Cunningham and Kemper 1998). While different aspects of health “safety nets” have been studied, including non-profit outpatient clinics and legal statutes with oversight on healthcare delivery (Horton 2006, Boehm 2005, Lamphere 2005, Horton et al. 2001), healthcare access has been one of the main topical issues addressed and the methodological approaches employed have been conducted outside of clinical settings. To date, only a few studies have been conducted in clinical settings and have drawn from ethnographic methods in analyzing patient experiences, albeit being among African American patients (Hudgins and Rising 2016), English-speaking adults (Baer et al. 2016), and parents of pediatric patients seeking medical evaluation for particular types of conditions (Watt 2015).

Reviewing the existing body of literature within the social and biomedical sciences illustrates the differential points of analyses in studying special patient populations in emergency care settings. While the researchers in medicine and public health have studied multiple aspects of health outcomes and experiences of special patient populations that have raised several areas concerns for clinical practice, the social scientific studies within this same area have disproportionately focused on critique and recommendations on large-scale reforms to some of the failures of the healthcare system. Public health and biomedical literature has begun to call for

the approaches, perspectives, and research skillsets of applied social scientists (Choo et al. 2015, Ranney et al. 2015), of which medical anthropology and ethnographic methods are well suited in addressing this void. This mixed-methods exploratory study builds on previous social scientific work involving Spanish-speaking patient populations and non-urgent use of emergency care services through ethnographic methods in a clinical setting. This study additionally focuses the point of analysis on how language (in the linguistic and cross-cultural sense) impacts patient experiences in emergency care settings. Unlike previous works that have specifically explored the roles of legal status and insurance coverage on the experiences and access of particular patient populations (Mulligan and Castañeda 2017, Castañeda 2017, Castañeda and Melo 2014, Melo and Fleuriet 2016, Chavez 1992), this study places language as a central point of analysis. While the aforementioned research has contributed in understanding the utilization practices of Latino/Hispanic patients, answering how chronic health conditions are syndemically exacerbated over time, and delineating the multi-level failures of health “safety nets” and the healthcare system, this study aimed to examine the salient issues Spanish-speaking patients face when they seek non-urgent care in emergency medical settings.

Guiding Theoretical Frameworks

Ethnographically studying the experiences of Spanish-speaking patients in emergency care settings necessitates guiding theoretical frameworks in the design, data collection, and analyses. Within medical anthropological thought there are a wide variety of conceptual approaches that can be combined to examine how language shapes the experiences of this patient population when they seek non-urgent care. This section outlines the guiding frameworks employed in this study, with a specific focus on how these concepts complement each other.

Medical Anthropology

Medical anthropology is the academic discipline that holistically studies human health problems and healing systems within particular sociocultural contexts (Brown et al. 2009). One of medical anthropology's hallmarks is its inherent interdisciplinarity, which offers depth in knowledge and valuable insights to social scientific and applied research because of its ability to simultaneously dissect the sociocultural and biophysical dimensions of health, disease, illness, and sickness (Brown et al. 2009). The discipline is not exclusively distinct from the other subfields in anthropology due to its considerable overlap and lack of a singular theoretical paradigm (Brown et al. 2009). The analytical lenses that the discipline provides can be understood to fall within six specific conceptual approaches: biological and ecological, both of which are concerned with the interactions of individuals and their physical environments; followed by the experiential, critical, ethnomedical, and applied approaches, all of which focus more specifically on how culture (understood here as the patterns of thought and behaviors of a group) influence health and sickness (Brown et al. 2009). Individually, each of these approaches raise ethical, methodological, and practical concerns for researchers, which is further complicated when taking into account that most forms of medical anthropological studies span across one or more of these conceptual approaches. The theoretical orientations of explanatory models and clinically applied anthropology will serve as the backbone to this study's analytical focus, methodological approaches, and collaborative aims.

Explanatory Models of Illness

Explanatory models was a theoretical framework proposed by psychiatrist-anthropologist Arthur Kleinman and was defined as the way individuals attribute meaning to their conditions of health, wellness, illness, and sickness (Brown, Ballard, and Gregg 1994, Kleinman 1978, Kleinman,

Eisenberg, and Good 1978). This framework conceptually draws from the ethnomedical and experiential approaches of medical anthropology in understanding how groups between different cultures as well as individuals within the same culture interpret the etiology, treatment, and outcome of illness or suboptimal states of health. Ethnomedical inquiry derives from the scholarly work focused on studying how different cultural groups contextualize illness, systematically organize medical treatment, as well as the social elements of treatment organization (Fabrega 1975). This perspective allows for medical systems to be compared in terms of 1) how the causal roots of illnesses are determined, 2) employed methodology of diagnosis, and 3) development of therapeutic interventions based on the diagnosis (Brown et al. 2009). The experiential approach in medical anthropology situates illness-related suffering at the center of analysis and focuses on three specific aspects: narrative, experience, and meaning (Brown et al. 2009). Each of these three aspects are respectively defined as the stories individuals use to discuss their illness; the sentiments felt and perceived regarding their illness; and the process that individuals use to make sense of their illness (Brown et al. 2009, Kleinman 1988). Explanatory models of illness conceptually integrate both of these approaches of medical anthropology by simultaneously recognizing the individual experience as well as the culturally learned health-beliefs among different groups (Brown et al. 2009).

Scholars have conceptually used this framework to delineate the consequences of divergent explanatory models between patients and healers/healthcare providers with regards to communication, treatment nonadherence, health seeking behaviors, and overall health outcomes (Baer et al. 2004, Brown, Ballard, and Gregg 1994, Kleinman, Eisenberg, and Good 1978, Chrisman and Johnson 1990). Anthropological research has demonstrated that explanatory models are not universal across a particular cultural group and can significantly vary depending

on the types of illness (Baer et al. 2004, Baer et al. 2008). Differential explanatory models have been identified in illnesses pertaining to chronic health conditions (Weller et al. 2012, Baer et al. 2008), sexually transmitted infections (Baer et al. 2004, Trotter II et al. 1999, Ingstad 1990), and terminal conditions (Chavez et al. 1995). This framework is particularly insightful because it offers a way of understanding the extent to which the models of patients and healers/healthcare providers align or diverge during the process of treatment negotiation.

Since language is one of the most critical aspects of culture, this study draws from the conceptual framework of explanatory models to further investigate how language discordancy between patients and providers impacts the patient experience, satisfaction, and understandings of the clinical encounter in an ED when seeking non-urgent care. This framework is essential in examining how Spanish-speaking patients contextualize and interpret causation of their medical conditions, understand the diagnostic process conducted by their providers, and comprehend both the treatment they receive in the ED as well as the follow-up treatment plan. This study additionally explores how explanatory models are employed by Spanish-speaking patients in describing their non-urgent symptoms in emergency medical settings. As outlined in the “Brief Histories: A Genealogy of Emergence Medicine” section earlier in this chapter, the ED is a clinical space that continually evolves and adapts to the sociodemographics of the communities it services. This presents a major contemporary challenge for EDs due to the increased interactions between Western clinicians and patients with potentially different explanatory models of illness (Brown et al. 2009). This complex interface of multiple explanatory models that occur on a daily basis in these clinical spaces bring to light the pertinence of this framework’s utility in studying the experiences of Spanish-speaking patients when they seek non-urgent care in emergency medical settings.

Clinically Applied Anthropology

Medical anthropological analyses enable researchers to offer unique insights that can be applied to designing and implementing interventions in either communal or clinical settings. Clinically applied anthropology specifically examines how sociocultural factors manifest in medical settings with respects to provider-patient interactions and communication, medical adherence to treatment, and how patients experience healing (Brown et al. 2009). This type of anthropological work has delineated how concepts like explanatory models can be useful in improving communication throughout the clinical encounter in a way that fosters health education and mutual understanding of how treatment plans can be negotiated between providers and patients. One of the strengths of clinically applied anthropology is its collaborative emphasis that recognizes both patients and medical providers as being involved in the culturally produced experiences, activities, and expectations throughout the clinical encounter (Anderson, Toledo, and Hazam 1982). This theoretical orientation approaches the study of health related social issues that arise in clinical settings in a non-adversarial way (often characteristic of critical medical anthropology) that situates both medical personnel and patients as collaborators in understanding the specific phenomena under study.

Another important aspect of clinically applied anthropology is anthropological praxes, in the methodological and the analytical senses. Here, Merrill Singer's (1995) frameworks of system-challenging and system-correcting praxes are crucial to contemplate in designing social scientific studies in clinical settings, employing methodological approaches to data collection, and analyzing findings in ways that advance scholarly understandings while also providing collaborators with valuable insights on how interventions can be implemented. System-challenging praxis goes hand-in-hand with critical medical anthropology, calling for research and

scholarly engagements that radically fragment institutional structures within medicine as a means of inciting systemic change. While ideal, this perspective can easily ignore the very positionality of the anthropologist, which most times is simply on the peripheries of biomedical hierarchies and hardly ever along the institutional structure itself. On the other hand, system-correcting praxis aims at working with existent structures in medicine that can be altered to improve systemic outcomes/functions (Singer 1995). This approach contrasts the perspectives of earlier medical anthropologists that critiqued some of the clinically applied work for not having larger impacts on the ways institutionalized Western medicine has failed marginalized communities and particular patient populations (Scheper-Hughes 1990). The central issue with both of these forms of praxes is to what degree social scientific researchers are able to translate their perspectives across disciplines as a means of co-developing interventions with institutional partners.

In this study, my multiple roles as a medical anthropologist, clinical research associate at the partnering ED, and native Spanish-speaking immigrant collectively influenced my interest in and ability to carry out this research. This recognition of my own intersectional positionality offers a way of not dichotomizing clinically applied anthropology as either being system-correcting or system challenging, but rather as both being achievable first through engaging in the former, which ultimately leads into the latter through a sustained relationship with collaborating health institutions in a type of system-transformative praxis. The principles of clinically applied anthropology and its praxes are important in studying how Spanish-speaking patients experience seeking non-urgent care in EDs as well as how they determine their satisfaction with the healthcare services provided to them, which is of importance to contemporary healthcare institutions (see “Brief Histories: Quality Healthcare and Patient Satisfaction”). Additionally, my

own intersectional position inspired the project's inception in a multitude of ways. First, it resonates with my own personal experiences as an immigrant in having to translate for different family members whenever someone became ill as well as some of the challenges we faced in navigating the U.S. healthcare system. My role as a clinical research associate facilitated designing a feasible study in an ED in a way that enabled mixed methods to capture multiple dimensions of how Spanish-speaking patients experienced seeking non-urgent care in this clinical setting. Recognition of this intersectional positionality and guiding frameworks raises several ethical challenges that had to be considered methodologically in conducting ethnographic work in an ED, and that are addressed in Chapter 7.

Complementary Concepts

While explanatory models and clinically applied anthropology theoretically frame the medical anthropological orientation of this study (respectively in terms of how language is examined throughout clinical encounters and the aims of this work), a missing aspect remains in understanding how Spanish-speaking patients make sense of their experiences when seeking non-urgent care in EDs. Explanatory models conceptually assist in identifying the concordant and discordant health-related perspectives between medical providers and patients, but do not necessarily delineate how patients experience seeking non-urgent healthcare services and clinical evaluation, perceive their satisfaction with these healthcare services, or fully understand information regarding their current health, inpatient treatment, and outpatient follow-up. In order to commit to medical anthropological research that is clinically applied, the conceptual approaches of *social determinants of health (SDH)*, *health-related deservingness*, and *health*

literacy are all valuable to this study's analyses as well as in the development of recommendations for clinical interventions.

Social Determinants of Health

Social determinants of health (SDH) is understood as the conceptual orientation that examines how social, economic, political, and physical conditions dictate health outcomes at the individual, communal, and population levels (World Health Organization 2010). This broad theoretical framework considers how health inequities across different populations are (re)produced as a result of unique social contexts and the dynamic interactions between influential social factors. These factors include socioeconomic status, education, occupation, social class, gender, and race/ethnicity (World Health Organization 2010). The collective influence of these aforementioned factors determines how individuals from different social positions experience vulnerabilities to health-compromising conditions in distinct ways (World Health Organization 2010). The social causation perspective of this framework argues that social factors, collectively yet indirectly, explain disparities in health where strictly biomedical factors cannot (Marmot and Health 2007, Marmot, Kogevinas, and Elston 1991). This allows for the distinction between the social causes of health disparities and the social factors determining the distribution of these causes, which cannot be reduced to mechanism-oriented theories of disease causation (World Health Organization 2010, Krieger 2002).

A SDH framework primarily emphasizes psychosocial factors associated with poor health outcomes and contends that the experience of living in social settings of inequality causes disadvantaged groups to compare their status and life circumstances to others (World Health Organization 2010, Raphael 2006, Raphael and Bryant 2006, Wilkinson and Pickett 2006). This in turn cultivates sentiments of shame and worthlessness among the disadvantaged that are

additionally coupled with chronic stressors that undermine health (Wilkinson and Pickett 2006). Lastly, another key component considered within the SDH framework is its recognition of power dynamics in understanding the pathways by which health inequalities and disparities are (re)produced though limiting the agency of disadvantaged groups within their sociocultural contexts (World Health Organization 2010, Wilkinson and Pickett 2006). Here power is understood as an advantaged group's ability "over" and/or "to" determine health decision-making in ways that disadvantaged individuals are denied an active role (World Health Organization 2010).

SDH is an important concept to consider in studying the experiences of Spanish-speaking patients seeking non-urgent care in EDs because it places the intersectional aspects of this patient population at the center of analysis. These aspects include the aforementioned influential social factors of socioeconomic status, education, occupation, social class, gender, and race/ethnicity. This study additionally builds from this conceptual orientation in examining where language and language discordancy between patients and medical providers function as influential social factors that determine health outcomes.

Health-related Deservingness

This study's second complementary concept of *health-related deservingness* can be defined as the scholarly examination of how legal and political statures qualify, entitle, or deem particular groups worthy (or not) of receiving certain rewards or assistance pertaining to health and access to them. Research on health-related deservingness has aimed to dissect how moral economies are constructed and understood in ways that include certain populations, while excluding others.

This body of social scientific work has predominantly explored welfare, disproportionately

employing a top-down approach through analyzing perspectives of policymakers and the general public (Willen 2012). Sarah Willen's (2012) work in health-related deservingness with unauthorized migrants refocuses the analytical lens and calls for a bottom-up approach in examining how those whose deservingness is being assessed perceive, understand, and make sense of their own worth, entitlement, and right to particular health and medical resources. While most of the work pertaining to health-related deservingness has explored undocumented/unlawfully present (im)migrants, I argue that this anthropological concept can be useful in studying how non-English speaking patients perceive the care they receive when they seek healthcare services in an ED (a clinical space where all patients are guaranteed to be seen), with a particular focus on language and explanatory models of illness rather than on legal status. While researchers have begun to elucidate the ways undocumented/unlawfully present im/migrant patients can suffer treatment delays, their associated healthcare complications, and ultimately, exacerbations of chronic health conditions, this study additionally aims to explore how language discordancy impacts these same phenomena and influence the patient experience of receiving care in emergency medical settings. This study attempts to answer Sarah Willen's (2012) call for examinations of how deservingness is reasoned by those excluded, which in this case is a group of patients whose dominant language creates barriers during the clinical encounter in emergency care settings.

Health Literacy

Lastly, *health literacy* is an important theoretical concept for understanding the experiences of Spanish-speaking patients in emergency medical settings because it provides insights into possible points of health education interventions among this patient population. Health literacy

can be defined as the ability to comprehend and act on instructions from medical providers regarding treatment, follow-up care, and health management (Shaw et al. 2009, Baker et al. 2008, Parker et al. 1999, Weiss et al. 1992). This concept has been employed by researchers in understanding how patient populations that disproportionately suffer from high burdens of disease related to chronic health conditions have limited access to health information as well as limited ability to process and apply this information (Shaw et al. 2009). Health literacy is an important concept to consider throughout the clinical encounter when considering how cross-cultural and linguistic differences between patients and providers can lead to misunderstandings of managing chronic conditions and adherence to treatment regimens (Shaw et al. 2009, Derose and Baker 2000, Carrasquillo et al. 1999). This study specifically drew from Sørensen's Health Literacy Model, which further defines health literacy as the ability to access, understand, appraise, and apply health information as a way of making health-related informed decisions in receiving or seeking healthcare services or resources that improve quality of life (Sørensen et al. 2012). This model lends itself to exploring Spanish-speaking patients' potential (mis)understandings regarding their present conditions, their visit to the ED, or follow-up treatment.

Conclusion

This chapter situated the study of Spanish-speaking patients seeking non-urgent care in EDs within the existing body of literature from public health as well as the biomedical and social sciences. The brief histories of EM and the quality healthcare movement in the United States were first presented as a way of elucidating EDs as unique clinical spaces for ethnographic study as well as the contemporary interests of healthcare institutions that align with the principles of

applied social scientific research of health. The following section of the chapter provided a review on the academic engagement by researchers in medicine and the social sciences with Spanish-speaking patient populations within clinical and communal settings, as well as investigations pertaining to non-urgent use of emergency healthcare services. This allowed for the identification of existing gaps within different academic bodies of literature. The final section of this chapter presented the theoretical backbone and complementary conceptual frameworks that guided the aims, design, methodological approaches, and analyses. These complementary conceptual frameworks include SDH, health-related deservingness, and patient health literacy. This study draws from the explanatory models of illness framework and the clinically applied paradigm of medical anthropology as a way of exploring how Spanish-speaking patients experience seeking non-urgent care in EDs, determine their satisfaction with the care provided, make sense of their own health-related deservingness, and understand their overall medical care, both in and out of the hospital setting.

CHAPTER 3: RESEARCH SETTING

Understanding the sociodemographics of the study region and the institutional healthcare site where this study was conducted assists in contextualizing the research settings. This chapter outlines these contextual factors by first describing the study region and county in order to delineate some of its language-based and health-related demographics. Emphasis is placed on Spanish-speaking populations, existing health disparities, and the healthcare services available within the county in institutional and communal settings. The second section of this chapter further contextualizes this study through discussing the characteristics of the partnering hospital, its ED, and the services available to patients seeking medical care. This institutional site will be referred to as “Metropolitan Hospital” in order to protect the hospital’s identity throughout the analyses of the study’s findings.

Study Region and County

Language-based Demographics

Hillsborough County is located along the Tampa Bay in west central Florida, housing approximately 1,376,000 residents within its three incorporated cities: Temple Terrace, Plant City, and Tampa (US Census Bureau 2016b). About 16% of the population in Hillsborough County was born outside of the United States (US Census Bureau 2016b). The self-identifying Hispanic/Latino population in the county is projected to be 363,767 (Robert Wood Johnson

Foundation 2017), ranking as the 4th largest county in the state in terms of actual population. This number represents 27% of the total county population (US Census Bureau 2016b), making it the 8th largest Hispanics/Latino county population in the state of Florida, in terms of proportion to other demographic groups within the county (Robert Wood Johnson Foundation 2017).

The Pew Research Center estimates the Spanish-speaking population in the U.S. to total 37,000,000, of which 73% speak Spanish as their primary language at home (Krogstad, Stepler, and Lopez 2015). These demographic studies additionally suggest that one-third of the total Hispanic/Latino population is not proficient in English (Krogstad, Stepler, and Lopez 2015). Subgroups composing the majority of this population with limited English proficiency (LEP) include women, individuals 65 or older, individuals with less than a high school education, and those born outside of the U.S. (Krogstad, Stepler, and Lopez 2015). The Spanish-speaking population in the Tampa-St. Petersburg-Clearwater metropolitan area is composed of about 368,000 Hispanic/Latino residents with an estimate that 272,300 identify Spanish as their primary language at home (Krogstad, Stepler, and Lopez 2015). Research indicates that 10% of the county's population report not speaking English "very well", which is similar to the estimated 11% of the entire population of Florida that self-reported the same English proficiency (US Census Bureau 2016a). This observed trend in English language proficiency makes Florida the 7th state with the highest share of residents with limited English proficiency, which is proportionally higher than the overall distribution of this population across the country (US Census Bureau 2016a). The existing modalities of communication with linguistic minority patients at Metropolitan Hospital include visually assisted translation/interpretation through the use of devices such as smart phones or tablets, audio-based translation/interpretation in the form

of 2-way communication phones, and medical personnel with varying degrees of medical Spanish proficiency. Understanding the general distribution of the Hispanic/Latino population in Hillsborough County, their preferred language use, levels of English proficiency, differences between demographic subgroups, and availability of translation/interpretation services at Metropolitan Hospital offers insight on some of the language-based disparities influencing communal health. This background information further establishes a foundation that situates language as an important variable of study in health-related research with the Spanish-speaking population in Hillsborough County.

Health-related Demographics

Another set of demographic data that should be considered to contextualize this study's setting is health-related disparities as well as available resources. The Robert Wood Johnson Foundation and University of Wisconsin's County Health Rankings and Roadmaps (2017) initiative ranks Hillsborough in the bottom 50th percentile of the 67 Floridian counties in terms of health behaviors and health outcomes. This assessment is partly due to the proportionally higher rates of health-related issues in comparison to other counties across the state, including adult smoking, adult obesity, excessive drinking, sexually transmitted infections per 100,000, and teen births (Robert Wood Johnson Foundation 2017). Premature deaths (defined as the years of potential life lost before age 75 per 100,000) are reported to be 6,800 within Hillsborough County, 6,700 across the state of Florida, and 5,200 among the top 10th percentile of US counties (Robert Wood Johnson Foundation 2017). Taken together, these population-based data and observed trends begin to broadly demonstrate how health education and health literacy could be two areas of

concern for the county in the development and implementation of health interventions among the general population.

Clinical care measures indicate the medically uninsured population of Hillsborough residents to be 18% overall and 22% among adults, with estimated healthcare costs of \$11,444 per resident in comparison to \$10,943 statewide. Health assessments comparing peer counties (Broward, Miami-Dade, Orange, and Palm Beach) in terms of size, demographics, public health resources, and funding per capita indicate Hillsborough County to have proportionally higher age-adjusted mortality rates due to chronic health problems such as cardiovascular (214.7 per 100,000) and hypertensive (21.4 per 100,000) diseases (Florida Department of Health 2016). Community-based studies within the county suggest that among the top ten health concerns of Hillsborough residents, half were related to chronic health conditions such as obesity, aging associated problems, diabetes, heart disease, and high blood pressure (Carnahan Group Strategic Healthcare Advisors 2016). Hillsborough residents have identified physicians and hospitals as their most trusted sources of healthcare-related information (Carnahan Group Strategic Healthcare Advisors 2016). This set of clinically derived and community-based data begins to shed light on the importance of addressing issues concerning chronic health conditions and the identification of healthcare providers and institutions as potential influential drivers of communal health among the residents of within Hillsborough County.

Research on health disparities between racial and ethnic groups in Hillsborough County identifies access to care, maternal and child health outcomes, and cause of death to be notably different when comparing Hispanic/Latino populations to their Black non-Hispanic and White non-Hispanic counterparts (Florida Department of Health 2017). In terms of access to care, Hispanics were proportionally less likely to have a primary care physician, have higher

uninsured rates (14%), and a significantly higher proportion of individuals reporting not being able to seek medical evaluation within the last year due to healthcare costs (Florida Department of Health 2017). Maternal and child health outcomes among Hispanics/Latinos residing in Hillsborough County are comparably worse than those of White-non Hispanics in terms of low birth weight (< 2500 grams), fetal deaths (per 1,000 deliveries), and infant deaths (0-364 days, per 1,000 births) (Florida Department of Health 2017). These same populations exhibited proportionally higher rates of births (26.5%) to mothers who are over 18 without a high school education (26.5%) than among White non-Hispanics (14.2%) and Black non-Hispanics (14.1%) within Hillsborough County, and comparatively to the rates across the state (Florida Department of Health 2017). Lastly, disparities related to cervical cancer as the primary cause of death among Hispanics/Latinos in Hillsborough County have been identified to be significantly worse in comparison to other racial groups (Florida Department of Health 2017). These studies additionally elucidate the areas where applied health research can contribute in addressing the communal needs of the Hispanic/Latino population in Hillsborough County.

Study Site

Overall Hospital Emergency Department Metrics

Metropolitan Hospital (pseudonym) is a private not-for-profit institution and comprehensive medical facility located in West Central Florida serving a patient population of about 4 million from surrounding counties. Metropolitan Hospital is licensed for just over 1,000 patient beds and is one of the largest hospitals in the state, offering healthcare services in more than 15 medical specialties. Between April 2016 and March 2017, the hospital was responsible for overseeing the care of proportionally more patients admitted for complications associated with chronic health

conditions in comparison to other hospitals within Hillsborough County (see **Table 1**). These data point to the importance of this hospital to the surrounding communities and highlights how it is an ideal healthcare site to study issues associated with chronic health among a variety of patient populations.

Hospitalizations associated with chronic health complications in Hillsborough County, Florida between April 2016 – March 2017.

Table 1. Hospitalizations associated with chronic health complications in Hillsborough County, Florida between April 2016 – March 2017.

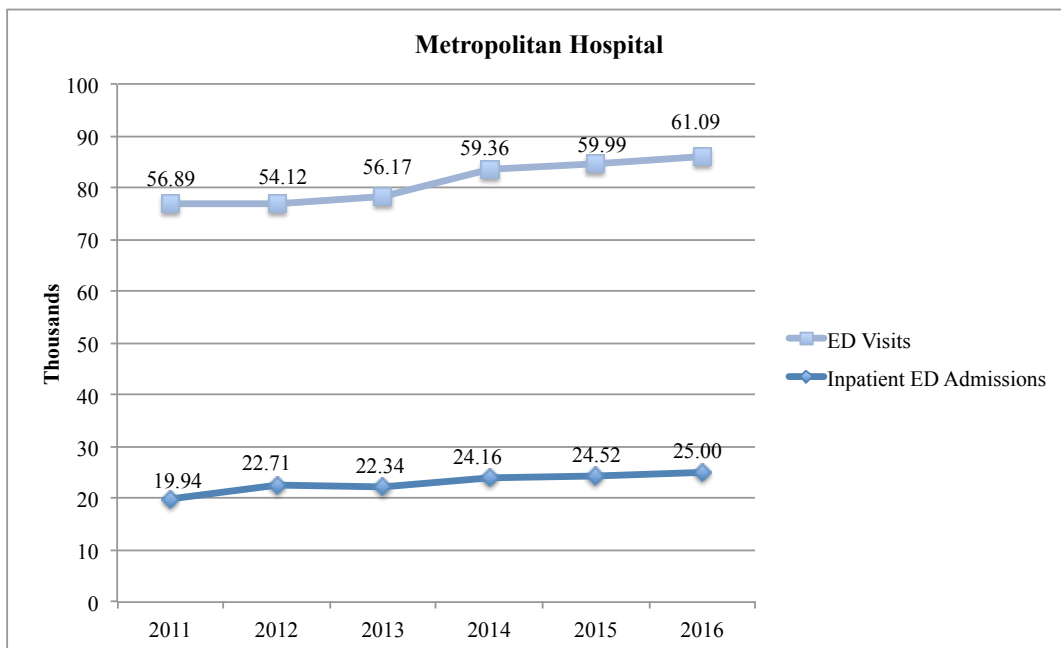
Reason for Hospitalization	Total Treated at Metropolitan Hospital	Total County Hospitalizations by Conditions	Percentage
Sickle Cell Disease*	451	690	65%
Cardiac Defibrillator & Heart Assist Anomaly*	132	237	56%
Migraines & Other Headaches*	261	627	42%
Hypertension*	216	714	30%
Inflammatory Bowel Disease*	162	543	30%
Chest Pain*	207	904	23%
Diabetes*	279	1360	21%
Heart Attack*	219	1076	20%
Renal Failure*	654	3336	20%
Heart Failure*	797	4145	19%
Asthma	109	635	17%
Chronic Obstructive Pulmonary Disease (COPD)	518	3605	14%
Pulmonary Edema & Respiratory Failure	205	1939	11%

* = Highest proportion of patients treated throughout the county

Source: Florida Agency for Health Care Administration, 2017

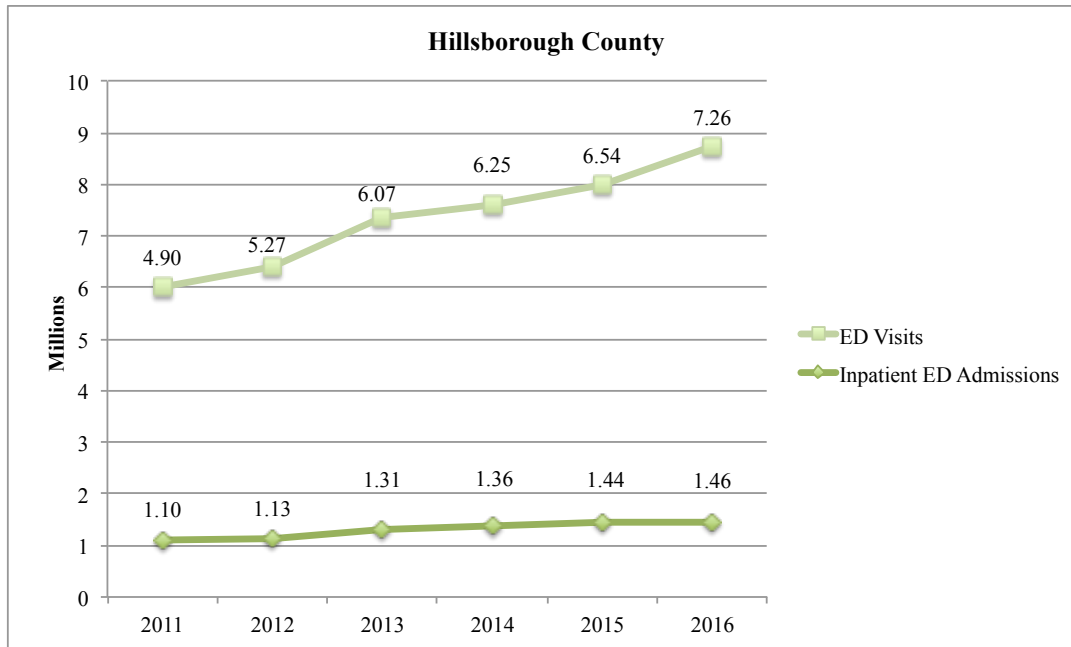
Metropolitan Hospital's ED treats a very high volume of patients annually, defined as 60,000+ yearly (Center for Medicare and Medicaid Services 2016). Statewide healthcare databases suggest an overall increase in the total ED visits at Metropolitan Hospital (see **Figure 1**) and hospitals within Hillsborough County (see **Figure 2**) within the last six years. In 2016, Metropolitan Hospital was responsible for overseeing the care of 16% of the total ED visits and 29% of inpatient ED admissions among the 10 hospitals with publicly available data (Agency for

Health Care Administration 2017). In terms of quality performance measures, Metropolitan Hospital compares similarly to other hospitals seeing 60,000+ unique visits per year in the percentage of patients who left the ED prior to being seen by a medical provider (**Table 2**). This healthcare institution performs better than other peer hospitals in the state and nationally in terms of the median time spent in the ED before being transferred to an inpatient room after medical providers have decided to admit a patient (**Table 2**). Areas for improvement for Metropolitan Hospital when compared to other peer institutions include the average times spent in the ED prior to being seen by a medical provider, as well as the time spent prior to inpatient admission or discharge (**Table 2**).



Source: Florida Agency for Healthcare Administration, 2017

Figure 1. ED visits and inpatient ED admissions at Metropolitan Hospital, 2011-2016 (in thousands)



Source: Florida Agency for Healthcare Administration, 2017

Figure 2. ED visits and inpatient ED admissions in Hillsborough County, 2011-2016 (in millions)

Table 2. Quality performance measures of Metropolitan Hospital and peer institutions across Florida and the US.

	Metropolitan Hospital	Other "Very High" Volume Hospitals	
		Florida	Nation
Percentage of patients who left the ED before being seen	2%	2%	2%
Average (median) time patients spent in the ED, before they were admitted to the hospital as an inpatient	363	313	336
Average (median) time patients spent in the ED, after the doctor decided to admit them as an inpatient before leaving the ED for their inpatient room	106	135	137
Average (median) time patients spent in the ED before leaving from the visit	240	161	172
Average (median) time patients spent in the ED before they were seen by a healthcare professional	35	24	27

Source: Centers for Medicare and Medicaid Services, (accessed Dec 17, 2017)

Other quality metrics suggest an overall trend among patients treated at Metropolitan Hospital to be satisfied with the medical team, procedural aspects of ED care, and hospital as a whole (**Table 3**). In terms of patient satisfaction, Metropolitan Hospital performs on par with other hospitals within Hillsborough County as well as other hospitals across the state and slightly underperforms in comparison to the national hospital average (**Table 3**). One caveat in interpreting these data is that these findings are reported from 2,837 completed surveys that represent an overall response rate of 17% (Center for Medicare and Medicaid Services 2016). Another limitation is that they provide overall averages with institutional performance as the main foci of analyses, where different patient populations are grouped together. The study employed for this MA thesis, however, specifically focuses on examining the how Spanish-speaking adult patients experience seeking non-urgent healthcare services in an ED as means of identifying areas of intervention for medical staff to improve patient health outcomes, patient comprehension, and overall satisfaction.

Table 3. Patient satisfaction measures of Metropolitan Hospital and peer institutions in Hillsborough County, across Florida, and the US.

	Metropolitan Hospital Average	Hillsborough County Average	Florida Statewide Average	National Average
Communication with Nurses	78%	78%	77%	80%
Communication with Doctors	76%	77%	78%	82%
Responsiveness of Hospital Staff	63%	63%	62%	69%
Pain Management	68%	69%	68%	71%
Communication about Medicines	61%	63%	61%	65%
Discharge Information	87%	86%	85%	87%
Overall Hospital Rating	74%	70%	68%	73%
Recommend the Hospital	77%	71%	70%	72%

Source: Centers for Medicare and Medicaid Services, (accessed Dec 17, 2017)
See data.medicare.gov and www.medicare.gov/hospitalcompare/search.html

Conclusion

The sociodemographics of the study region and its health-related measures both in the general population and among Hispanics/Latinos provide a way of contextualizing why language-based disparities may influence both chronic health and the ways Spanish-speaking patients experience care. Hillsborough County is a unique case study for conducting research among this patient population because of its prevalence of predominantly Spanish-speaking residents with LEP as well as the burdens of chronic health conditions across the county. Additionally, chronic health conditions and complications have been disproportionately reported by residents as their primary health concerns with physicians being their most trusted source of healthcare information. The ED at Metropolitan Hospital, as an institutional healthcare site, is an ideal place to ethnographically study the experiences of Spanish-speaking patients that seek non-urgent care because of the high volume of patients and proportion of county residents seen annually at this hospital, especially for issues concerning chronic health conditions and associated complications.

CHAPTER 4: METHODOLOGY

This exploratory study employed a cross-sectional design and mixed methods approach in examining the experiences, perceptions, and satisfaction of Spanish-speaking patients seeking care in an emergency department (ED). The research team for this study consisted of an emergency medicine physician resident, a trained undergraduate research assistant, and myself (a graduate student). Three distinct methods were utilized for data collection: 1) participant observation in the ED and shadowing with patients during different parts of their stay, 2) administration of a patient satisfaction survey that incorporated elements of previously validated quality assessment tools (n=100), and 3) semi-structured interviews with patients after physician disposition regarding their follow-up/ continued care plan and prior to being discharged or admitted (n=25).

Patients recruited and consented into the study had to meet the following inclusion criteria: be at least 18 years of age; identify Spanish as their preferred language of communication; and be seeking non-urgent medical evaluation. As defined in Chapter 1, non-urgent ED use are clinical encounters that do not require immediate medical attention such as active resuscitation for cardiac conditions or stabilization of a patient that has sustained life-threatening trauma. Trained medical personnel determine acuity levels after patients have registered and have been assessed during triage. EDs in the United States currently use the Emergency Severity Index (ESI), a 5-level triage algorithm that assigns patients into different groups in order of severity of their present condition and need of clinical resources (Elshove-

Bolk et al. 2007). Patients classified/assigned an ESI score of 3H, 3V, 4, or 5 by ED staff were eligible to be included in the study considering these triage acuity levels were not immediately requiring medical attention. Patients classified with an ESI score of 1 or 2 are in the most critical need of medical attention (such as traumas and cardiac arrests) and were thus excluded from being recruited and consented into the study. Patients were additionally excluded from participating if they met inclusion criteria but had any past medical history of psychiatric/mental health conditions that would impede the process of obtaining informed consent, were under the custody of law enforcement officials, or were presenting to the ED for evaluation of substance or alcohol use. Patients were screened for eligibility with the assistance of medical staff and were consented after being triaged.

Verbal informed consent was obtained from patients willing to participate in the study. The very nature of conducting ethnographic work is filled with uncertainty and informality (Metro 2014, Annas 2006, Bradburd 2006, Katz 2006), which is magnified within the inherent unpredictability of the ED setting. Introducing a formalized written consent process could have presented barriers in establishing a rapport with eligible participants and in getting them to honestly share their opinions with me. Social scientists have observed and reported on these issues in ethnographic work, where consent forms make potential participants suspicious of why the study is being conducted for some activities that are perceived to be seemingly informal (Metro 2014). Utilizing a formal informed consent process is further complicated when considering the translation of required technical terms that are difficult to understand both linguistically and cross-culturally (Metro 2014). As a result, verbal informed consent was used in order to minimize interference with the workflow of the medical team overseeing the patient's care and to facilitate the building of rapport with an already vulnerable patient population. While

written informed consent is optimal, verbal informed consent was considered more feasible because of the context and setting in which the study was being conducted. As an immersed participant in the ED, I wanted to maximize the building of trust with eligible patients that were already vulnerable in an uncertain environment because of the language barrier, as well as other potential factors relating to health insurance coverage or legal status. Insurance coverage or legal status were not included as direct demographic questions in order to minimize the power differentials between myself as the researcher and the participating patients. This information was only discussed with patients if they shared this with me throughout any parts of data collection. The consent form was reviewed with eligible patients and a Spanish copy of the consent form was provided to each patient, outlining the purposes of the study, how the data collected would be used, and providing contact information of the research team should they have any questions. This study was approved by the University of South Florida's Institutional Review Board (Pro00029308).

Participant Observation and Patient Shadowing

The first phase of this study involved participant observation to understand the ED as a clinical site where the explanatory models of hospital staff and patients interface on a daily basis. This method offered a way of studying the culture of medical professionals working in emergency medical settings (including physicians, nurses, and ancillary staff), the day-to-day functions of an ED, as well as the interactions and communication between patients and medical staff. There are two forms of participant observation, passive and active (DeWalt and DeWalt 2011). Each of these approaches to this method provides different types of insights of the environment being studied. Passive participant observation was conducted in different parts of the ED including:

waiting areas, triage rooms, hallways, and staff consultation areas. This approach to participant observation provides a way of studying organic interactions in a particular setting because the researcher is not influencing the behaviors between individuals, in this case patients and medical staff, through direct social interaction (DeWalt and DeWalt 2011, Kawulich 2005). It is important to consider the researcher's role in the use of this ethnographic method because they play a role in the types of behaviors exhibited by group members through being present in the scene (DeWalt and DeWalt 2011, Clifford and Marcus 1986). My positionality as a clinical research associate at the hospital assisted in being perceived as another member of the staff, which facilitated being able to conduct observations with patients and medical staff alike, without making them feel uncomfortable.

Active participant observation provides a way of situating the researcher as an engaged actor in the particular situations being observed (Johnson, Avenarius, and Weatherford 2006, Kawulich 2005) while also fostering the building of rapport with the individuals in these settings (Hoffman and Gardner 2006, Johnson, Avenarius, and Weatherford 2006). Active participant observation was conducted through patient shadowing, where a researcher accompanies a consented patient during different time periods throughout their stay in the ED. This relatively new approach to active participant observation offers the researcher a different vantage point in conducting observations because it allows for a more visceral understanding of the patient experience. Patient shadowing has been employed to study the clinical encounter and the experience of receiving medical care through the perspective of patients as a way of understanding how different hospital departments can improve patient satisfaction metrics (DiGioia III et al. 2010). There is only one study to the best of my knowledge that has used this

approach to anthropologically study the ways in which physician-patient communication and overall patient experience can be improved (Baer et al. 2016).

Field notes were the data collection technique used throughout this phase of the study. The jotting and logging practices of field notes (Bernard 2011) were used to document behaviors, expressions, and interactions in the ED. These techniques provided the most useful way of capturing the events as they occurred *in situ* (Schensul and LeCompte 2012). Field notes were taken either through physical writing and electronically on a research tablet, depending on where observations were being made in the ED. Physical field notes appeared not to make patients uncomfortable while I was shadowing them, whereas electronic note taking appeared to impact the building of rapport. Conversely, the use of electronic field notes appeared to be more socially acceptable when conducting observations in waiting areas and around staff.

These approaches to participant observation provided a way of exploring the norms of the ED as well as the clinical encounter from different vantage points, especially from the perspective of Spanish-speaking patients (Emerson and Pollner 2003). The use of participant observation additionally facilitated the determination of appropriate complementary data collection methods (DeWalt and DeWalt 2011) in a way that do not interfere with how the ED normally operates. The data obtained from this phase in the study is presented as clinical ethnographic vignettes of unique experiences of Spanish-speaking patients.

Modified Patient Satisfaction Survey

As discussed in Chapter 2, the emergence of the “quality movement” in healthcare can be traced back to the 1980s in response to the significant rise of health-related lawsuits that characterized the 1970s (Press 1997). A few verified quality assessment survey tools have been utilized by

healthcare institutions to measure patient satisfaction such as the Press Ganey Survey introduced during the mid-1980s and the more recent, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. During the second phase of this study, a patient satisfaction survey was designed and translated into Spanish to include elements from both of these widely used quality assessment tools. Additional components included in the survey were items regarding the modality of communication staff used while providing care to the patient, satisfaction with modality of communication, and the degree to which hospital staff maintained patients informed on the status of their visit. All questions in the survey included ordinal responses as well as a visual analog scale (VAS), in order to operationalize patient satisfaction in distinct ways. VASs have previously been used in quality improvement studies in healthcare settings (Stiffler and Wilber 2015). Consented patients were surveyed after the attending physician provided information during the disposition portion of the visit and prior to the patient being admitted or provided discharge paperwork. Patient surveys typically lasted between 15-20 minutes.

Semi-Structured Interviews

The final phase of this study employed the use of semi-structured interviews to qualitatively explore and contextualize the experiences of Spanish-speaking. A total of 25 Spanish-speaking patients were recruited and consented into this phase of the study. All interviews were conducted in Spanish by a member of the research team in either patient rooms or hallway treatment areas. Interviews generally lasted between 20-30 minutes during the patient's stay in the ED. The semi-structured interview guide was designed to descriptively elicit how patients generally felt about their interactions and communication with hospital staff, their satisfaction with the care they

received in the ED, and their experience throughout their time in the ED from beginning to end. A research team member wrote down participant responses as they conducted the interview, where answers were initially shorthanded and jotted down notes were taken. These shorthanded notes were then expanded after research team member concluded interviews with the participants. Direct quotes from patients were written down whenever possible throughout the interview. Ethnicity was not explicitly asked in the semi-structured interview guide for the dual purpose of the study's aimed at understanding the influences of language discordancy on the experiences of patients and the fact that the Spanish-speaking populations that present to this clinical space are not fixed to a predominant ethnic community. This method complements the data collected in the first two phases because it offers a way of exploring how participants perceive the topics being studied, while also allowing for newly emergent topics to be discussed and be considered as valuable qualitative data to be analyzed (Bernard 2011).

Data Analyses

Data collected in each phase of the study were analyzed using a variety of approaches to holistically understand how Spanish-speaking patients experience the clinical encounter and perceive the overall care they receive. Field notes from patient shadowing and observations in the ED were subjected to a thematic analyses where the behaviors, documented events, and general observations made were qualitatively coded. The *a priori* codes used in the initial analysis of these data pertained to discordances in explanatory models between patients and the medical staff overseeing their care, perceptions on satisfaction with care provided, and patient perceptions regarding seeking non-urgent medical evaluation in and ED. Field notes were analyzed after each patient encounter and consequently discussed with members of the research

team as a way of determining consensus of observed *a priori* themes as well as themes that organically emerged during fieldwork.

Clinical ethnographic vignettes are used to elucidate some of the recurrent themes that emerged throughout conducting participant observation and patient shadowing in the ED. This technique in data presentation draws from the anthropological tradition of using thick description as a way of illustrating the situational contexts of the observed behaviors, expressions, and interactions (De Munck 1998, Geertz 1973). The vignettes presented in the next chapter were selected because of how these specific instances provide an ethnographic snapshot of the recurrent themes observed throughout patient shadowing and participant observation during different times of day, areas within the ED, and in the presence of different staff members. Thick descriptions of each event are used to illustrate the situational contexts of the participants' sentiments as well as observed behaviors among both patients and staff members (De Munck 1998, Geertz 1973).

Quantitative methods were utilized to analyze the data obtained from the modified patient satisfaction survey. The Statistical Package for the Social Sciences version 24 (SPSS24) data analysis software was used to for the analysis of the data collected in this phase of the study. Descriptive statistics were first used to understand the demographics of the participating patients. Univariate and bivariate statistical analyses were additionally employed to quantitatively study potential relationships and correlations between the dependent and independent variables of interest. The dependent variables of interest to this study were: age, sex, location of receiving ED treatment (in a private room vs hallway), time of day (morning, afternoon, evening), day of the week, whether participants presented to ED evaluation by themselves or accompanied by someone else, and modality of translation use, if any. The independent variables of interest

included: patient satisfaction, overall awareness and understanding of their medical care, as well as patient perceptions of medical staff concern.

Lastly, the data collected from the semi-structured interviews were analyzed similar to the qualitative data in Phase 1 of the study. Participant responses were coded and entered into a database by two members of the research team. Coding for each set of responses occurred independently and were compared after two different members of the research team entered the data onto a developed electronic research database. Upon comparison, discordant codes were discussed between the research team members and reconciled to have one final set of identified codes to be analyzed. In addition, SPSS24 was used to analyze general trends in participant responses and assess for the prevalence of recurrent themes. Specific participant quotes are presented to further illuminate some of the predominant themes. Taken together, this form of analysis complements the quantitative results from the patient satisfaction survey by further contextualizing the experiences of Spanish-speaking patients through their own words and additionally building off of the ethnographic data collected during Phase 1 of the study.

Ethics, Ethnography, and the ED

One particular complexity of social scientific research that significantly contrasts biomedical research is the inherent fluidity and unpredictability of social interactions that can occur during data collection. This unique aspect eliminates the concept of “control” that is popularly employed in biomedical investigations, and increases the possibility of ethically challenging scenarios to arise for social scientists. This section discusses some of the primary ethical challenges surrounding researcher neutrality in conducting ethnographic work in emergency care settings.

Context of Research and Ethical Framing

Whiteford and Trotter (2008) discuss the importance of identifying any vulnerability or special conditions that may apply to the research subjects under study or other implicated individuals. In this case, the consented patients can be potentially vulnerable subjects because of factors such as limited health insurance coverage, compromised states of health, and/or limited agency in accessing particular forms of medical treatment. A key factor to consider in this scenario is where along the hierarchy of power differentials the researcher occupies. My previous experiences in pre-hospital emergency settings as an Emergency Medical Technician, patient triage and information management as a medical scribe, and patient screening in emergency intervention studies as a clinical research associate all provide some validity to hospital staff on my understanding of ED operations and inherently provide more access than a researcher with no prior similar experiences. Regardless of having more “professional” capital in this scenario, I still find myself at the peripheries of the biomedical hierarchy as I am not a licensed medical provider at any level (physician, physician-assistant, nurse, etc.). This is where the ethical challenges of ethnographic studies begin to surface in considering the imbalances of power between the patient populations, the researcher, and the hospital staff. While patients in these research scenarios are the most vulnerable, the researcher also has some degree of vulnerability in terms of maintaining access to the setting.

The vulnerabilities of both the researcher and the patient raised questions as to whether I have ethical rights and responsibilities to the patients or physicians under study. The primary sponsor for this type of project is the ED staff and educational administration of the hospital. Taking this into consideration, a part of the study design must benefit the sponsors

whether it be through improvement of hospital operations or providing evaluations for increasing patient satisfaction ratings. On the other hand, the patients under study should also be able to benefit from participating in the research. Short-term/direct benefits for patients from participating in the research could be the researcher further clarifying particular treatment plans the medical staff ordered and provide a more detailed explanation on the discharge orders or follow-up plans. The long-term benefit (while ideal) is to improve hospital operations so that emergency staff can better connect patients with communal resources they can use in non-urgent cases.

This study considered the three tenets of the Belmont report of respect for persons, beneficence, and justice. Respect for persons was particularly considered in the design of the research to avoid traceable or identifiable information pertaining to any of the participants. Beneficence resonates in the limited involvement of the researcher during patient-provider interactions and the overall goal of contributing information to the collaborating hospital in improving experiences of this special patient population. The principle of justice behind this type of project is present in the simple undertaking of such a study, as no current body of scholarly work is specifically focused in ethnographically investigating ways to improving experiences of Spanish-speaking patient populations in emergency care settings.

Ethical Challenges with Ethnography in the ED

The primary ethical dilemma faced in this study was maintaining researcher neutrality throughout patient shadowing and semi-structured interview phases of data collection. The scenarios that arose during these phases were 1) patients requiring translation during a medical evaluation and 2) observing dynamics between patients and their visitors while they

translated/interpreted for the patient. Both of these scenarios were inherently associated with the methodologies and guiding theoretical frameworks of this study. These scenarios are evident in the clinical ethnographic vignettes presented in Chapter 5, where I simultaneously played dual roles as a researcher and an active participant in the care of consented patients. The first scenario occurred most frequently as the patient or medical staff requested my assistance in translating during medical evaluations and other parts of the ED visit. The dilemma of researcher neutrality arises when considering that I became a more active actor in the social situations and interactions under study. The pressing ethical challenge in this scenario was questioning whom I had ethical obligations to. Either side I decided to assist may convey or demonstrate partiality, especially in considering that I would be serving as a language and cultural bridge between the patients and provider. The problematic element of translating is the inevitable involvement of my own perceptions, worldviews, and understanding of disease/illness that could influence the perspectives and behaviors of either patients or providers, respectively.

The second ethically challenging scenario pertaining to researcher neutrality was raised in situations where complete patient autonomy was not exercised. Examples of these situations includes when a patient's family or friend translator miscommunicated information to either the medical staff or the patient themselves as well as instances where these individuals made decisions for the patient prior to discussing matters with them. Caridad's experiences in Vignette 4 highlight this very scenario. These situations during data collection placed me in a considerably precarious situation. The same question emerged here in determining whom I have ethical obligations to. An internal dialogue that I went through was in debating whether I had the obligation of informing the physician of medical team about the miscommunication of information (even if minor) and potentially compromise the trust of the patient in attempting to

“do some good” or should respect the patient’s trust in their family translator and possibly risk the prolonging of necessary diagnostic exams or certain medications (in more serious situations)? Either course of action raises multiple unintended consequences in terms of patient safety, patient trust, trust of medical team, and where the boundaries of active involvement in part of the researcher are necessitated.

Possible Solutions and Selected Course(s) of Action

Determining possible courses of action to resolving these types of ethical dilemmas requires creativity and thorough brainstorming in order to determine the best option or combination of actions during the designing of ethnographic work. The option that must always be considered in any ethically challenging scenario is the “do nothing” approach (Whiteford and Trotter II 2008). This course of action is grounded on the argument that choosing to carry out an action with the intent of “doing some good” can result in more harm to a participant than not doing anything at all (Fluehr-Lobban 2002). A possible action brainstormed in responding to the first scenario of either the patient or a member of the medical team asking me to translate during a medical evaluation is to honor the request when either party asked. An alternative course of action brainstormed was choosing to only honor the request of either the patient or medical team, but never both equally. A potential action in responding to a scenario where a patient’s family translator miscommunicated information to a medical provider is to correct the information the moment I witness this event. An alternative option brainstormed was in correcting the misinformation immediately following a medical evaluation in a space where both the patient and provider were not present in the same room.

Based on the possible solutions in dealing with the aforementioned scenarios that ethically jeopardize researcher neutrality, the best combination of actions decided prior to data collection was to take the “do nothing” approach, provide translation only when asked by the patient, and timely clarifying miscommunicated translation to the medical team whenever they were no longer with the patient. Doing nothing in this case would be applied to the situations where the patient’s translator was communicating with a member of the medical team. Personally, choosing to provide translation only when the patient asked was determined to be an appropriate course of action as the patient may not have another alternate option of directly communicating with the medical staff if they did not arrive to the ED with a family translator or if another modality of communication was offered. In the ED setting the other possible forms of communicating with non-English speaking patients are through either using the translation services as well as the use of other medical staff such as Spanish speaking nurses to provide translation. Taking into considerations all of these factors, I decided to only intervene and provide translation for the patient in the event that all other options have already been exhausted as a way to minimize my influence on the interactions between the patient and provider.

The combination of “doing nothing” and providing translation/interpretation only when asked by patients was consciously incorporated in the methodological design of the project. The scenario where I foresaw that I would most likely be asked by a member of the medical team to translate for the patient would be in during the patient shadowing component of fieldwork. Similarly, the events where I foresaw having a higher probability of being asked by a patient to translate for them would also be during this phase of data collection. The predetermination on the courses of action to be taken should these types of ethical challenges arise was further mitigated by the recognition of the availability of Spanish-speaking staff as well as the patients being

accompanied by a family translator. This course of action in dealing with the scenario of a patient requiring translation during a medical evaluation bears in mind the principles of “do no harm” in minimizing my active involvement in the patient-provider interactions under study. The principle of justice resonates with deciding only to intervene and provide translation when asked by the patient. I could only imagine that the patient would ask me to translate in the event of all other options being exhausted and otherwise unavailable to them. The patient would have also been in an increasingly vulnerable state because of their worries and motivating factors for seeking emergency care, not to mention their inherent powerless position by simply being a patient. Deciding to not translate when asked by a patient was personally determined to be morally unjust.

Deciding to clarify or correct miscommunicated translations to the medical providers in a timely manner stems from the potential for incorrect information to dictate the standard of care for the patient. The reason for clarifying incorrect information when the physician is not in the same room with the patient is to not compromise the trust of the patient and of the family translator, as well as to ensure the overall well being of the patient so that the provider can make an informed decision on what particular diagnostic exams to order. This decision is supported when keeping the principles of justice and “do some good” in mind. Researcher neutrality is maintained when communicating with the provider separately from the patient, which may also be perceived as “doing some good” by the provider. This action is also just as I would have a difficult time defending not intervening in correcting miscommunicated information and this resulting in a negative consequence for the patient.

Conclusion

Application of anthropological inquiry in studying special patient populations in EM is subject to many ethical challenges in terms of methodology. The guiding frameworks of such scholarly and applied work raise considerable ethical concerns with implications for the research subjects, the researcher, and other groups, such as the hospital ED team. Researcher neutrality in this particular type of project is an especially important factor to keep in mind, as access and overall impact of the data collected would be compromised for an already limited body of literature with pressing need in both the general public and academic spheres. This chapter provided an outline of triangulated methodological approaches in studying the experiences of Spanish-speaking patients seeking non-urgent care in EDs. This chapter additionally presented ethical challenges and potential courses of action in addressing these challenges to offer one of many possible approaches in developing *an* anthropology of EM in ethnographically studying special patient populations. Taken together, other theoretical and methodological angles can be employed from different vantage points in developing other anthropologies of EM.

CHAPTER 5: RESULTS

This chapter presents the findings from this exploratory mixed-methods study. The first section offers clinical ethnographic vignettes from the data collected in Phase 1 of the study via participant observation in different areas of the ED and shadowing patients during their stay. The selected vignettes outlined in this section contextualize the experiences of Spanish-speaking patients and highlight five unique instances that occurred during different times of day, areas within the ED, and in the presence of different staff members. The second section of this chapter presents the results obtained from the administration of the modified patient satisfaction survey to 103 patients who met the eligibility criteria and consented to participate in the study. These results includes overall trends in participant responses as well as multiple statistical tests conducted with the Statistical Package for the Social Sciences version 24 (SPSS24) data analysis software to assess for significant associations among the overall set of responses. This section additionally includes a retrospective analysis of an existing patient satisfaction dataset from Metropolitan Hospital. This retrospective analysis is included in this section in order to compare the experiences of Spanish-speaking patients to that of English-speaking patients. The final section of the chapter presents the qualitative findings from the semi-structured interviews with 25 Spanish-speaking patients, showing general trends in participant responses and specific quotes. These types of data collectively present distinct, yet complementary forms of understandings of patient how Spanish-speaking patients experience seeking non-urgent care in

the ER. The data presented in this chapter was de-identified through providing individual participants with pseudonyms.

Participant Observation and Patient Shadowing: Clinical Ethnographic Vignettes

Over 120 hours of participant observation were conducted in ED waiting areas, medical consulting areas, treatments areas and triage rooms. Thirty of these hours consisted of shadowing 10 patients who consented to allow me to accompany them throughout different parts of ED visit. The clinical ethnographic vignettes delineated here represent the main themes observed throughout this phase of the study:

- Consequences of language discordancy between patients and medical staff, lack of awareness or understanding of the diagnostic process in the ED
- The use of Western biomedical understandings of health and illness
- Self-conceptualizations of how deserving patients consider themselves to particular healthcare services
- Issues in patient autonomy throughout the clinical encounter
- The health-seeking behavior of waiting until symptoms progress to become significantly worse

Vignette 1: “Fijate mijo, que soy diabética y ni siquiera eso le pude decir”

Riding into the entrance bridge of the hospital, I knew it would be a busy day by the sheer number of cars making their way to the parking facilities. Getting into the hospital was considerably slower, in part attributed to the three ambulances also trying to get to the

emergency entrances. “Hopefully today goes smoothly”, I thought to myself, and every other time I arrived at the hospital parking lot. Throughout my time in emergency care settings I have come to learn what many individuals who regularly work in these clinical spaces adopt as a norm: the reality that only uncertainty is certain. “What brings you into the ED today?” “Providing your signature here is just an acknowledgement that we are a teaching hospital”. “Smith! I’m looking for Mr. Smith”. “Yes, this is the neuro resident under for Dr. Smith. When was the patient last seen normal?” “Attention staff. We have a trauma activation coming by ground. ETA 10 minutes. Medical team 3 doctor please respond”. These are but a few of the many things I overheard on my two minute commute from the entrance of the ED waiting areas to my designated research team station, passing by triage rooms, consulting areas, and a wide array of medical staff along the way.

After getting settled, I went to do my first set of rounds in the medical team and nursing staff areas to identify any predominantly Spanish-speaking patients currently in the ED. “Try room 2, she’s been here for some time. We’re still waiting on some of her labs”, recommended one of the ED residents. I made my way over to the patient’s room, knocked on the door, introduced myself, and explained why I was asking for permission to accompany patients during some parts of their stay. After going over the informed consent form, I began asking the patient some questions about her visit and her experience in the ED. “Well look at these. They’re all over my arms and legs.” Here Yamaira, a 32 year-old Cuban woman was showing me some irritated red spots she said began a few days prior and were beginning to concern her since they would not go away. “I tried some creams and Vaseline at home to see if that would help, but after two days of it not really getting any better I went to the clinic early this morning after dropping off my two girls at school. I was hoping to get some answers there, but they just told

me to come here to get seen by the doctors. It's 4 in the afternoon, I've been here since 10 in the morning, and I have the slightest idea what type of tests they are doing. I hope someone comes to finally tell me what this is and what I can do or take, so I can go home."

I followed up by asking what her thoughts were on the possible causes of the symptoms she was experiencing, to which she responded: "God knows. At first I thought it was because of some new bed covers I recently got. After it seemed to get worse, I began thinking it was a type of parasite you commonly see in Cuba that causes you to have a similar type of skin reaction. I especially thought this because I was just there about a month ago visiting family. That's why I am here, to hopefully get some answers and solutions." Upon asking if she was able to explain these concerns to the ED staff overseeing her care, Yamaira expressed difficulties in communicating with the doctors and nurses. "They used a phone that was blue to ask me questions. I tried to explain to the translator on the phone what was going on, but they only asked me a few questions and I was not able to tell them everything. I mean... I'm diabetic and I could not even tell them that. But, it also was not like they asked me either." I went on to ask whether the blue phone was used throughout her entire stay or only during the initial parts of her visit. "After they asked me those few questions, I haven't been able to speak to anyone else. They come to get tests and I just say 'Ok, Ok', hoping that they'll tell me something later." As she was recounting her experience with communicating with the medical team during her visit, I noticed Yamaira simultaneously taking out a small black Accu-Chek machine from her purse. "62. You see that's low", she stated as she showed me the reading on the machine after pricking her right index finger.

At this point in the conversation Yamaira asked if it was possible for me to talk to any of the medical staff to see whether she could have two little orange juices. "I haven't eaten since

before getting here.” I agreed to go speak to the medical team and see if she was allowed to have a drink or snack. On my way out of the room Yamaira additionally asked if I could also ask the staff on any updates to her tests. “I’d really appreciate any information. You come to this room and it feels like you’re in limbo waiting to hear something while everyone passes.” Understanding this all too familiar experience, I went on to speak to the resident to see any updates she could provide.

Reflections

This vignette presents a few emergent themes I came across during this phase of the study, the first of which was issues relating to the inability of patients and physicians to fully communicate with each other. While Yamaira did not present to the ED for evaluation of a chronic condition per se, the inability to fully communicate with the medical team appeared to play a role in explaining her medical history and other important medical information, such as her diabetes. This theme additionally points to some of the downsides in using technology-based translation/interpretation services in an ED. Yamaira’s experience of feeling lost or in limbo in the ED is a sentiment commonly experienced by patients that present for non-urgent conditions. This vignette begins to elucidate how this experience of feeling uninformed and lost during an ED stay is further magnified among patients who do not speak the same language as the medical personnel overseeing their care.

The second emergent theme in this vignette pertained to the serious health conditions of patients that may still be classified as “non-urgent” according to the ESI algorithm. While Yamaira was presenting for evaluation of rash-like symptoms, her past medical history of diabetes was important to consider in part due to the length in time of her evaluation while in the

ED. This theme further highlights how the language and communication barriers between Yamaira and the medical team overseeing her care impeded her from being able to provide a detailed medical history.

The third emergent theme was Yamaira's use of the Western biomedical explanatory model of disease and illness in trying to make sense of the rash-like condition that brought her to the ED for further evaluation. This perspective is closely related to Yamaira's seeking of answers and possible treatment solutions to relieve her symptoms. Prior to beginning fieldwork and this phase of the study, it was hypothesized that this patient population would use different explanatory models of illness in making sense of their symptoms and conditions. Each of these themes continually surfaced while conducting patient shadowing and participant observation in the ED.

Vignette 2: "Este no es nuestro país"

It was around 5PM on a Thursday and the ED was in its usual evening state of hustle and bustle. Emergency medical technicians (EMTs) gave nurses reports on patients who arrived by ambulance, military medics-in-training rushed to the trauma bay, and patient care techs escorted discharged patients to the elevators. While wrapping up some notes at one of the ED computer stations, I received a call on the clinical communication device used by staff members. "Hey, we have a Spanish-speaking patient going to room 3 that meets study criteria." I thanked the nurse for alerting me and told them I would follow-up with the patient a little later during their visit to the ED.

After about two hours I went into the room, introduced myself to the patient and her husband, and explained the purposes of the study. "Yes of course, anything to help", stated the

patient after asking her whether she would be interested in participating. Natalia, a 61-year-old Cuban female and lung-transplant patient, came to ED after developing shortness of breath that appeared to progressively worsen over the last three days and having a fever the night prior to the visit. “I had a lung transplant a few months ago in Gainesville. I was strictly told by my transplant doctor to be very careful with my health and to take my medications on time. Specifically the one that is called Prograf, so my body does not reject my new lungs. I have to take all the precautions, which is why I came here because the Theraflu I was trying at home did not help me get better.” Noticing how informed Natalia was in explaining her condition and managing her health on a daily basis, I asked her what her thoughts were on the possible causes of her symptoms as well as what concerns she had overall. “The first thing that crossed my mind is, ‘Ay no, I hope it’s not my lungs failing.’ The fever worried me because that’s usually a sign that something is not right with my health. I feel better that I am here because I know I’m in good hands.”

In asking Natalia about her experience in communicating with the medical team she explained how professional and courteous the entire staff had been. “Everyone was very welcoming and respectful in treating us today.” Probing Natalia to further explain how easy or difficult it was to communicate with staff, she indicated being accustomed to using the blue phone whenever available in her hospital room, to explain things to the medical staff. “You obviously prefer to have someone that can speak your language, but we are very happy with any help they can provide. We understand that this is not our country and that Spanish is not what everyone speaks. We feel lucky when we find someone that is Spanish-speaking whenever we come to the hospital, but if no one is available, we try to find a way to make them understand us. In what we can of course, because sometimes you don’t have to opportunity to tell them

everything, know how to say it in English, or know whether or not the translator on the phone communicated everything we say.” While I was almost done jotting down notes as Natalia spoke to me, the radiology technician (RT) walked into the room. He introduced himself, “Hi there, I’m from radiology.” “Sorry papa. Only Spanish”, responded Natalia immediately. She then looked over at me and asked if I could please translate. I introduced myself to the RT and explained to both Natalia and her husband that the RT came to get a chest X-ray to see if something was going on with her lungs. Natalia looked back over to the RT and said “Ok, no problem”. As the RT unlocked the bed and began transporting Natalia back to the radiology area, her husband gathered their belongings. As we all stepped out of the room, I thanked Natalia for allowing me to talk to her and wished her a speedy recovery from her symptoms. She responded by saying, “No, mil gracias a ti papito por hablar con nosotros y traducir para nosotros.” (No, many thanks to you son for speaking with us and translating for us).

Reflections

Similar to Vignette 1, Natalia’s experience highlights a strong use of Western explanatory models in making sense of her symptoms, managing her health, and seeking symptom relief at home. In the same light as Vignette 1, Natalia’s case also presents a qualitative argument of how “non-urgent” and “not serious” are conceptually not synonymous. This vignette points to the seriousness of Natalia’s symptoms despite not actively requiring immediate medical attention in an ED setting.

Listening to Natalia share her sentiments regarding her satisfaction with the care she was being provided surprised me, because it stood in stark contrast to the experience of English-speaking patients I have previously studied in a different research project. While not completely

universal, English-speaking patients seeking non-urgent care appeared to be dually concerned with both their symptoms/health conditions and with the customer service they received while in the ED. This vignette introduced another emergent theme observed during this phase of the study: the gratitude expressed among this patient population for any healthcare services provided. Here one can see how Natalia's perspectives indicate a sense of luck in having the medical team attempt to communicate with her and her husband. Instead of having someone speak her language as a demand or requirement, she was thankful for any attempts made by the medical team to understand what she was trying to communicate to them. This sentiment of luck, gratitude, and appreciation for any attempts to provide healthcare services in Spanish is summed together when Natalia discussed how this was not her country. Here she expressed that the responsibility in being able to communicate with the medical team fell mostly on her and other patients like her. This theme would continually resurface in other interactions with Spanish-speaking patients in the ED.

Vignette 3: "Tuve que aprender como reclamar ese servicio para que me tomaran en serio"

I met Maritza, a 29 year-old Puerto Rican woman and cancer patient, and her aunt around 10PM, after they had been in the ED for approximately three hours. She recounted arriving to the ED via ambulance after experiencing nausea, dizziness, and severe pains at home. When asked to describe her experience in the ED, Maritza shared her long history of cervical cancer and having to frequent multiple hospitals since her diagnosis. "You sort of get used to their world after coming so often. Cancer is obviously a scary thing to face, but it's even scarier when you can only, at best, minimally communicate with the doctors or nurses." I followed up by asking how she went about communicating with medical personnel whenever she is in a clinical setting. "It

definitely helps when I have a family member with me, like one of my cousins. However, there's not always going to be someone available to come with me. If I'm alone I immediately request Spanish or the blue phone. Before, I felt afraid or shy to ask, but over time you lose that. I had to learn how to request this service so that they could take me seriously." Maritza attributed this change in attitude and outlook to her cancer diagnosis, explaining how she used to not be as assertive in trying to communicate with healthcare personnel overseeing her care prior to being diagnosed and undergoing treatment. "I understand how busy they can get. However, I can't think of a worse feeling than when you're in an intense amount of pain, have troubles communicating, and feel like no one is paying you attention. It is a very desperate feeling. Although it may not appear that way to them, we don't come here because we want to. There are really not many other choices." Maritza shared her personal challenges in getting some of the nurses and medical team members overseeing her care to understand the pain she was experiencing in previous hospital visits. "When you can't explain how you are feeling clearly, you can't help but feel ignored or as if your pain is not that serious." During some of her initial hospital visits, Maritza described the difficulty in requesting translation services in Spanish out of fear, and recounted how she became more comfortable at requesting these services both because of the severity of her pain and the increased frequency of visits she had while undergoing cancer treatment.

Reflections

This short vignette builds off the emergent themes from the first two, as Maritza describes the circumstances that led her to learn how to request healthcare services in Spanish in order to communicate her needs. In this case it was Maritza's pain associated with cervical cancer treatment. This vignette reintroduces one of the themes from the first vignette where the inability

of being able to speak English to the medical team incited sentiments of frustration. The frustration stemmed from feeling overlooked or not heard by the medical team, which translated into feeling as though her concerns were not being taken seriously. This interaction with Maritza made me wonder whether more serious health circumstances are the bases for patients to become more avid self-advocates in these clinical scenarios or if this was just a special case. Maritza's experience was the most visceral of the patient shadowing conducted in this phase of the study because of her vivid descriptions of difficulties in communicating with different medical personnel during her frequent clinical visits. This vignette additionally presents how "non-urgent" does not equate with "not serious", as Martiza's associated health complications from cancer treatment was a very serious matter noticeable in the ways she was describing her pain. Maritza's experiences also begin to highlight some of the power dynamics present in the clinical encounter between predominantly English speaking medical personnel and Spanish-speaking patients. These power dynamics continually emerged in different ways while conducting participant observation and patient shadowing.

Vignette 4: "Solo cuando es absolutamente necesario"

"Only when absolutely necessary." The prolonging of seeking health services or medical evaluation was a sentiment shared by many patients I had the opportunity of shadowing during their stay in the ED. Caridad, a 40-year old Mexican woman patient with a month history of left-side pain following a motor vehicle accident, and Ramiro, a 42-year old Guatemalan man experiencing three weeks of right-side eye pressure, are but two case examples of this health seeking behavior. When I met Caridad around 3PM on a Tuesday afternoon, I could tell she was having trouble comfortably sitting on her bed while she was conversing with me. Caridad

discussed the events that led to her current symptoms, stating: “My brother and I were involved in a car accident about 6 weeks ago while driving to Plant City. I was scared of what it might cost me to go to the hospital if I got checked out right away. I thought the pain would go away after the first 2 weeks, but it was really hard to work especially when it involves taking care of children.” I asked Caridad why she waited until that day and time to come to get seen in the ED, to which she responded that she tried all other options she could first. “The clinic I went to couldn’t find anything and just told me to buy Ibuprofen at the pharmacy for the pain. That helped minimally and got me through work for the next week or so. When I went back to the clinic, they just prescribed me a stronger type of Ibuprofen and told me to come here if the pain got worse.”

While conversing with Caridad in her room, her sister-in-law, Jenny, walked in. Thinking I was a part of the medical team, she introduced herself to me in English and began informing me of Caridad’s current situation. “Don’t worry, he speaks Spanish”, said Caridad, followed by explaining the reason I was in the room with them. As the conversation continued, I asked Caridad to describe how she goes about communicating and understanding medical personnel when she seeks healthcare services. Pointing to her sister-in-law she went on to say, “I don’t know what I’d do without her. Right?” “Yes, she’d have a really hard time communicating since she only knows very few words and gets embarrassed too”, replied Jenny. She went on to mention that the very fact Caridad came to the ED was an indicator that the pain was very serious.

I accompanied Caridad and Jenny for another few hours, where we discussed multiple topics. One of the topics that interested both of them, and other participants, was my ethnicity and how I knew Spanish. Explaining my Japanese and Dominican background was received by a

“Mira que curioso! Muy interesante” by Caridad. It was not much longer after we continued to talk that the physician walked into the room to inform Caridad about the three broken ribs revealed by X-ray imaging. During this entire encounter, the physician was only speaking to Jenny who would follow-up with more questions while Caridad looked at Jenny. As an observer it appeared that Jenny was making decisions for Caridad prior to explaining or asking for her input. I felt uncomfortable observing this interaction and wanted to interject to ask if Caridad’s input would be considered but also felt this would create an even more uncomfortable situation for everyone. Not knowing what to exactly do in this scenario I looked at my watch. It read 6:54PM. I decided it was time to excuse myself. I told Caridad that I had to go, thanked her for allowing me to keep them company while in the ED, and wished her a speedy recovery. The physician and Jenny were still talking as I walked out of the room.

After I finished rewriting my field notes in the break room, I wondered if there was another patient in the ED I could speak to. I proceeded to walk towards the medical team areas on the far end of the ED to do another round of asking staff for other possible participants. One of the attending physicians recommended going into room 7, where I met Ramiro. Having been in the ED for a few hours, he immediately agreed to participate and allow me to accompany him for the rest of his stay. Ramiro described developing a discomfort in his right eye that turned into a pressure-like feeling within the last few weeks. “It has bothered me before, but I tried to pay no mind to it. It was when I was working outside today that I got really concerned because everything looked blurry. I knew something was not OK, so I stopped working for the rest of the day and waited until one of my coworkers finished his shift to ask him for a ride here.” The conversation continued and I asked Ramiro to describe his experience in the ED. “It is a lot of waiting but what else can you ask for? They are the professionals who know best, so you just

have to be a patient...well...patient”, to which we both simultaneously laughed. Ramiro detailed his interaction with the medical staff, discussing how no translation service was used.

I curiously asked why he, a predominantly Spanish-speaking patient, did not ask for a translation service. “Well, I know a few words and tried to describe how I was feeling to the best of my ability. While I may not know English, well...like you, I would say I can defend myself in trying to explain how I’m feeling.” Ramiro later went on to explain how his nurse and doctor knew a few Spanish words as well, jokingly stating “We found a way to understand each other.”

Ramiro expressed a similar sentiment to that of Caridad, in explaining his reasoning and decision-making process in determining when to seek healthcare services. “It has to reach a point where I physically cannot tolerate the pain anymore or when it comes in between my job in construction, that I’ll then go to get seen by the a doctor. It is the same with my high blood pressure and diabetes.” Having just conversed with Caridad prior to accompanying him, I asked Ramiro to explain whether he has felt intimidated, shy, or embarrassed in asking questions whenever a member of the medical team interacted with him. “You certainly feel that, but you can’t be afraid to ask. A lot of my friends and family members experience that *verguenza* (shyness), which makes it all the more confusing because we already have troubles understanding English 100%. I still try to get any update from them whenever they come in. I’ll say ‘Everything OK?’, and they’ll tell if yes or no.”

An RT came into the room and stated she came in to take Ramiro to get a CT scan of his head. “Yes”, he replied. As the RT verified Ramiro’s hospital band, he quickly looked over at me and asked, “She said I’m being admitted?” I explained that they were going to run an imaging test of his head to see if they found something. “Ah OK, yes very good. Thank you!” he responded to the RT. At this point it was about 9:30PM and I thanked Ramiro for allowing me to

accompany him. He thanked me for coming to talk with him and I left as he was being taken to the radiology department.

Reflections

This final vignette introduced two other emergent themes in the experiences of Spanish-speaking patients: the concept of patient autonomy during the clinical encounter and the practice of waiting until symptoms progress to the point of becoming significantly worse. Caridad and Ramiro provide case examples at opposite ends of the spectrum in terms of having autonomy throughout their visits in the ED. Caridad was reliant on the help of her sister-in-law to the point where it appeared she was not making decisions for herself whereas Ramiro relied on his limited English to communicate with the medical team. Caridad's experiences were consistent with previous research that identified translation from family members to have similar effects of miscommunications (Flores et al. 2012). In both examples, the patients still had limited understandings of what was happening during their ED visit as well as what diagnostic tests were being conducted. My conversations with both Caridad and Ramiro continued to reveal the inherent power dynamics that manifest in the clinical encounter between predominantly English-speaking staff members, patients who do not speak English as a first language, as well as the translators/interpreters (whenever present). The waiting until symptoms worsened was evident in both of these participants' cases, despite still being considered non-urgent or not time sensitive conditions. The lack of insurance played a role in both cases, but the inability to fully communicate with staff members was just as salient to their experiences in the ED.

Summary of Participant Observation and Patient Shadowing

The clinical ethnographic vignettes presented in this section begin to delineate some of the unique experiences of Spanish-speaking patients seeking non-urgent care in an ED. The inability to fully communicate with the medical team was a central theme conveyed by participants, limiting them in expressing their concerns, communicating their medical information, and understanding what was happening with their care while in the ED. It also contributed to a secondary theme of issues in patient autonomy, where some patients expressed feeling limited or restricted in their involvement with their ED care. This speaks to some of the inherent power dynamics involved with patients who do not speak English as a first language since they are reliant on someone else or translation/interpretation service in order to communicate their medical concerns.

Health-related deservingness emerges in the answers of the participants as they describe their rights to have medical care in their primary language. Here we see varying perspectives on how deserving patients consider themselves of being treated with a medical team that is able to communicate in their primary language throughout the entire clinical encounter. Some participants placed the responsibility in being able to communicate with the medical team on themselves, whereas others learned over time to request translation/interpretation services.

Modified Patient Satisfaction Survey

Patient Demographics

A total of 103 patients were recruited and consented into this phase of the study by one of the research team members, consisting of an emergency medicine physician resident, a trained research assistant, and myself (a graduate student). Three of the participants that consented into

the study did not complete the entire modified patient satisfaction survey because they decided to no longer participate. The average age of the surveyed patients was 51 years old, with a majority of the participants being in their late 30s and mid 40s (**Figure 3**). Eighteen participants refused to provide their age at the time of the survey administration. Fifty-four percent of the patients consented into the study were female and 65% of the total participants were surveyed in ED rooms. Overall, the median time the study's participants spent in the ED was 5 hours and 45 minutes, with a majority of them presenting for medical evaluation while being accompanied by a family member (**Figure 4**). Median values are used given the high skew presented by patients with conditions that necessitate either a good amount of ED resources or very few diagnostics for medical evaluation. 75% of the surveyed patients arrived to the ED through driving themselves, having a friend or family member bring them to the ED, using public transportation, or using local transport services. Table 4 presents the chief complaints reported by consented participants.

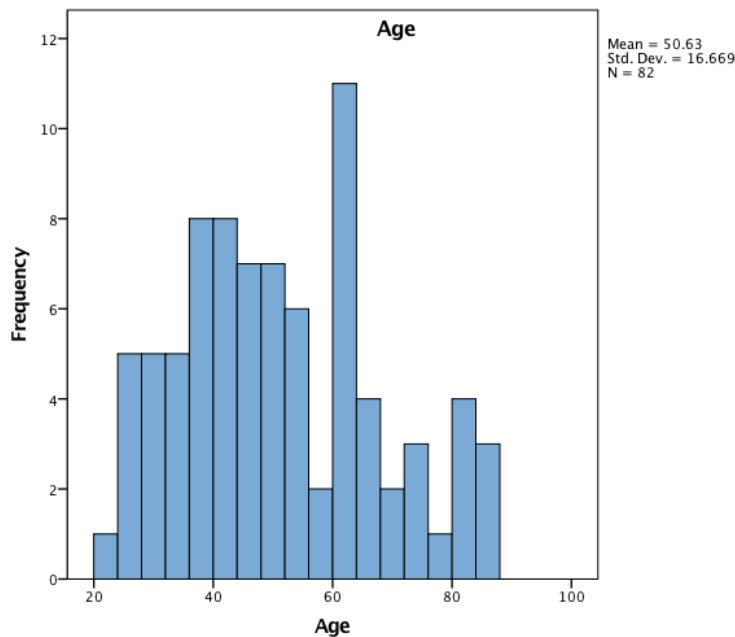


Figure 3. Frequency distribution of participant ages, interval width=4 years.

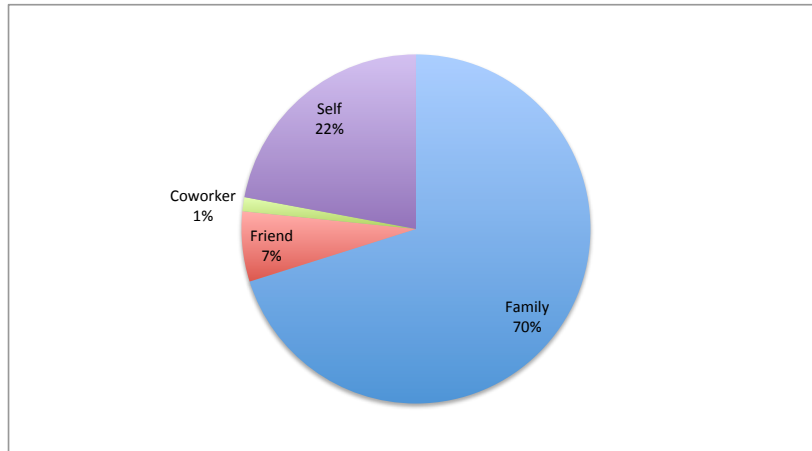


Figure 4. Percentage of patients being accompanied by someone when presenting for medical evaluation in the ED.

Table 4. Participant Chief Complaints upon Presenting to the ED (N=100)

Chief Complaint	Frequency	%
Abdominal Pain	31	22.1
Vomiting	10	7.1
Extremity Pain or Swelling	7	5.0
Injury	7	5.0
Urinary Problems	6	5.7
Weakness	6	4.3
Back or Flank Pain	5	3.6
Blurred Vision or Eye Problem	5	3.6
Headache	5	3.6
Nausea	5	3.6
Pelvic Pain	5	3.6
Abnormal Labs	4	2.9
Chest Pain	4	2.9
Diarrhea	4	2.9
Pregnant	4	2.9
Gynecological Problems	3	2.1
Shortness of Breath	3	2.1
Fall	2	1.4
Post-Motor Vehicle Collision	2	1.4
Post-Operative Complications	2	1.4
Rectal Bleeding or Blood in Stool	3	2.1
Arthritis	1	0.7
Cervical Cancer	1	0.7
Cough	1	0.7
Diabetes	1	0.7
Dizziness	1	0.7
Fever	1	0.7
Fibromyalgia	1	0.7
Hypotension	1	0.7
Kidney Stones	1	0.7
Mass	1	0.7
Neck Pain	1	0.7
Numbness	1	0.7
Palpitations	1	0.7
Rash	1	0.7
Throat Pain	1	0.7

Survey Findings

The distribution and trends of participant responses suggest an overall positive experience for Spanish-speaking patients seeking non-urgent medical care. A majority of patients appeared to perceive the triage and initial ED intake staff to be either helpful (47%) or very helpful (48%). On average, the patients perceived their wait time to be short in the waiting room (59%) as well as after being assigned a treatment area in the ED (room or hallway) and prior to being seen by the medical provider (55%). While most of the patients reported their nurses demonstrating concern in addressing their needs (69%), 53% of the patients reported feeling not informed or

under informed throughout their ED visit. With respect to nurses, surveyed patients additionally reported that their privacy was taken into consideration while they received care in the ED (51 %) and that their concerns were taken seriously (58%). Sixty-one percent of the patients surveyed reported understanding their nurses to be either clear or very clear.

Similar trends in responses were observed among questions pertaining to patient perceptions on the medical provider overseeing their care. A majority of the patients perceived that the physician evaluating them in the ED paid attention to their needs (83%), was concerned while providing treatment (69%), and took their concerns very seriously (76%). Perceptions regarding how informed the patients felt by the physician overseeing their care were similar to the responses pertaining to the nursing staff, where 51% reported feeling not informed or under informed by their physicians while receiving care in the ED. Despite this trend in responses, 54% of patients reported being able to understand what the physician communicated to them whenever they directly interacted in the treatment areas.

Among the patients who presented to the ED while being accompanied by a family member or friend, a majority reported their visitors to be treated very well (77%). Additionally, 54% of visitors present with the patient reported feeling not informed or under informed throughout their stay in the ED. Aside from the physicians and nurses, most of the patients surveyed reported perceiving the rest of the medical team to demonstrate a lot of care for their concerns (65%). These team members include paraprofessional and ancillary staff such as patient care technicians, registration staff, security, and social services. Of the patients who reported experiencing pain when initially presenting to the ED, 66% reported their pain being very well controlled while receiving care in the ED. In terms of understanding the information provided regarding follow-up care or continued care in the hospital, 38% of surveyed patients reported

having difficulty in understanding their follow-up care plans while only 35% reported no difficulties in understanding. Twenty-eight percent of the patients reported having a fair understanding of what they needed to do after leaving the ED. Overall, the patients surveyed positively rated their experience in the ED (76%) and reported being very likely to recommend the ED at Metropolitan hospital to their family and friends (58%). Table 5 presents the overall distribution of participant responses in the modified patient satisfaction survey.

Table 5. Modified patient satisfaction survey responses

Question	Responses	Frequency	%	VAS Average	Question	Responses	Frequency	%	VAS Average
How helpful was staff that first asked you about your condition?	Not Very Helpful	6	6.1	68.5	How concerned were doctors in treating you?	Not Concerned	3	3	74.8
	Helpful	47	47.5			Somewhat Concerned	28	28	
	Very Helpful	46	46.5			Very Concerned	69	69	
How was the waiting time in the waiting room?	Very Long	7	7.2	64.7	How seriously did the doctor take your problem?	Not Seriously	2	2	78.5
	Long	8	8.2			Somewhat Serious	22	22	
	Fair	25	25.8			Very Seriously	76	76	
	Fast	32	33			Very Difficult	3	3	
	Very Fast	25	25.8			Difficult	13	13	
How was your waiting time before seeing a doctor?	Very Long	6	6.3	62.9	How clear was it to understand the doctor?	Fair	30	30	63.8
	Long	11	11.5			Clear	18	18	
	Fair	26	27.1			Very Clear	36	36	
	Fast	29	30.2			Very Poor	1	1.2	
	Very Fast	24	25			Poor	2	2.5	
How much attention did the nurses show for your concerns?	Very Little	4	4	70.3	How was your family or friend treated?	Fair	16	19.8	74
	Little	6	6			Good	25	30.9	
	Fair	21	21			Very Good	37	45.7	
	Good	33	33			Not Informed	22	26.2	
	A lot	36	36			Somewhat Informed	23	27.4	
How informed did the nurses keep you during your stay?	Not Informed	31	31	54.5	How informed did the staff keep your family/friend during your stay?	Very Informed	39	46.4	57
	Somewhat Informed	22	22			Very Little	1	1	
	Very Informed	47	47			Little	0	0	
How concerned were the nurses for your privacy?	Not Concerned	6	6	66.2	How much did the staff care about you?	Fair	34	34	71.6
	Somewhat Concerned	43	43			Good	24	24	
	Very Concerned	51	51			A lot	41	41	
How seriously did the nurses take your problem?	Not Seriously	8	8	69.4	How well was your pain controlled?	Very Poor	2	2.6	69.8
	Somewhat Serious	34	34			Poor	8	10.5	
	Very Seriously	58	58			Fair	16	21.1	
How easy or difficult was it to understand the nurse?	Very Difficult	3	3	64.1	How clear was the information given to you about caring for yourself at home?	Good	21	27.6	52.8
	Difficult	16	16			A lot	29	38.2	
	Fair	20	20			Very Difficult	6	6.9	
	Clear	27	27			Difficult	27	31	
How much attention did the doctor show for your concerns?	Very Clear	34	34	75.6	What is your overall rating of ED experience?	Fair	24	27.6	74.3
	Very Little	2	2			Clear	7	8	
	Little	3	3			Very Clear	23	26.4	
	Fair	12	12			Very Poor	1	1	
	Good	40	40			Poor	2	2	
How informed did the doctor keep you during your stay?	A lot	43	43	55.3	How likely would you recommend our ED?	Fair	22	22.2	71.6
	Not Informed	36	36			Good	32	32.3	
	Somewhat Informed	15	15			Very Good	42	42.4	
	Very Informed	49	49		Very Unlikely	6	6		
					Likely	36	36		
					Very Likely	58	58		

The primary modality of communication between medical providers and Spanish-speaking patients during intake of the individual histories of present illness (HPI) was audio-based services (via a translation-specific phone or other medical communication device) (Figure 5). The secondary modalities used to communicate with patients at this same time point were the

use of present friends or family members (21%) and other medical staff who were either bilingual or partly proficient in speaking Spanish (19%) (**Figure 5**). A different trend is observed in examining the distribution of communication modalities with patients at disposition, the time point during the ED visit where medical providers determine the course(s) of action for continued medical care either through discharge and outpatient follow-up or through admission into the hospital for further evaluation. At disposition, a notable difference is observed in the use of translation services where 38% of the patients surveyed in the study were provided with their discharge or admission information from a staff member who was either bilingual or partially proficient in Spanish (**Figure 5**). Surveyed patients generally reported the modality of communication with the medical staff to be either helpful (45% during the HPI and 51% at disposition) or very helpful (47% during the HPI and 43% at disposition).

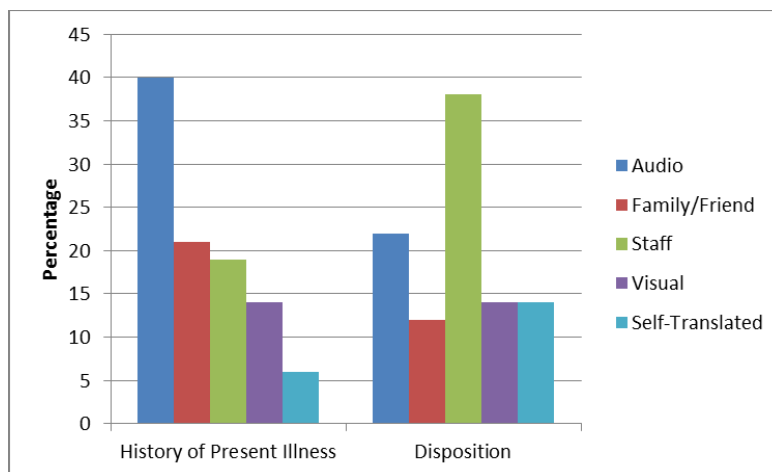


Figure 5. Modality of communication at different time points during ED visit.

Quantitative Analyses

Aside from Likert-scale responses, the survey tool was additionally designed to ask participants to delineate their perceptions and understandings using a visual analog scale (VAS) for each

question. These data provide an additional form of analysis that complements other methods used in this study. SPSS24 was employed in statistically analyzing the quantitative results from the survey responses. This approach was used in order to assess for significant patterns and associations between some of the dependent variables and participant responses. The dependent variables of interest included: sex, age, location of treatment in the ED, and modality of translation.

Chi Square tests for association were conducted on participant responses, followed by Student's t-test for independence on VAS values indicated by participants after every question. These statistical tests revealed several significant associations and trends among participant responses. In terms of communication, visually assisted translation/interpretation services in the ED were associated with fewer negative responses from the study participants in comparison to audio services (blue phone or clinical communication devices). This trend was observed in questions pertaining to the perceived helpfulness of medical staff during the HPI, how informed patients felt by nursing staff throughout their ED visit how informed patient visitors were by the ED staff through their visit, and clarity on follow-up care instructions at disposition (**Figures 6-9**).

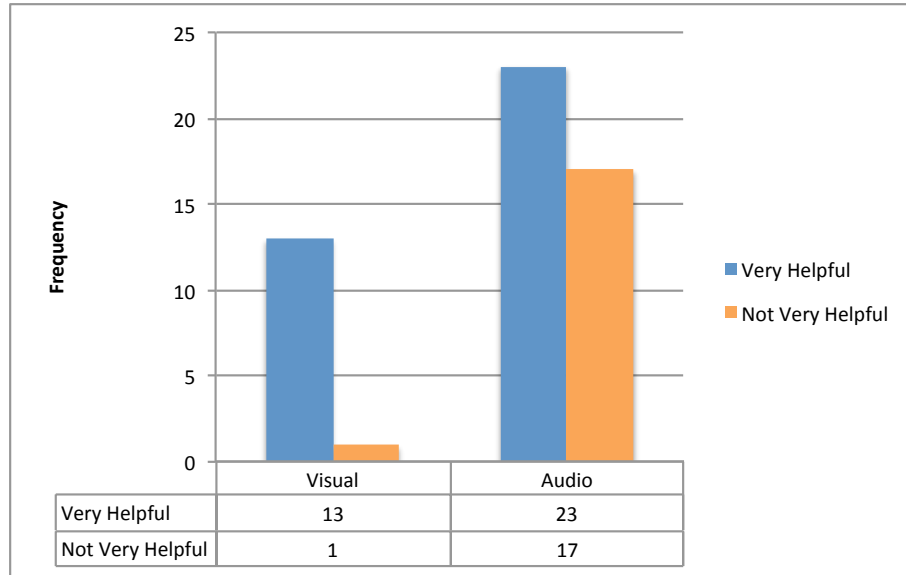


Figure 6. Perceived helpfulness of medical staff during the HPI by modality of communication ($X^2 = 5.8$, $df=1$, $p= <0.01$). Visual mean= 87.1, audio mean= 64.9, $t= 3.3$, $df= 31.3$, $p= <0.01$.

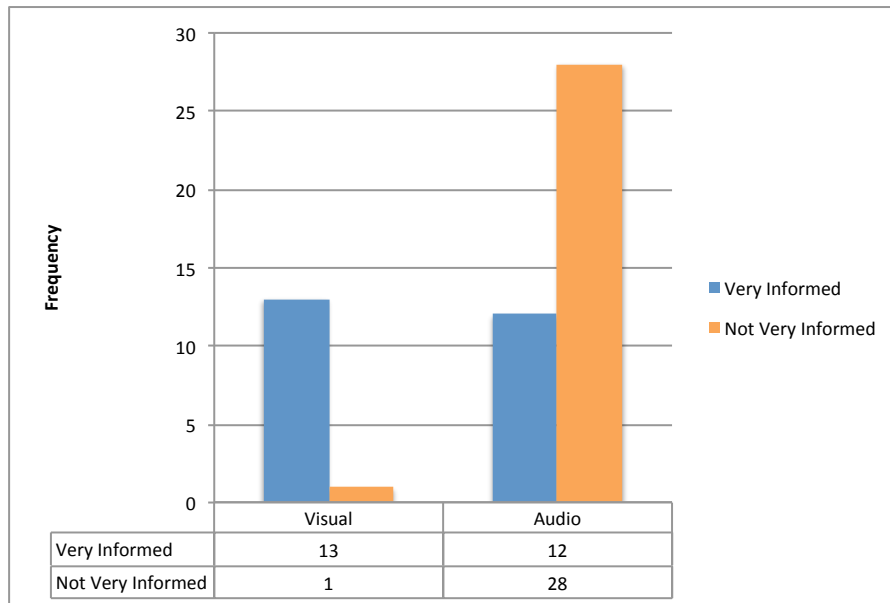


Figure 7. Patient perceptions of being informed by nursing staff throughout the ED visit by modality of communication ($X^2 = 16.5$, $df=1$, $p= <0.01$). Visual mean= 83.6, audio mean= 39.3, $t= 5.1$, $df= 31.3$, $p= <0.01$.

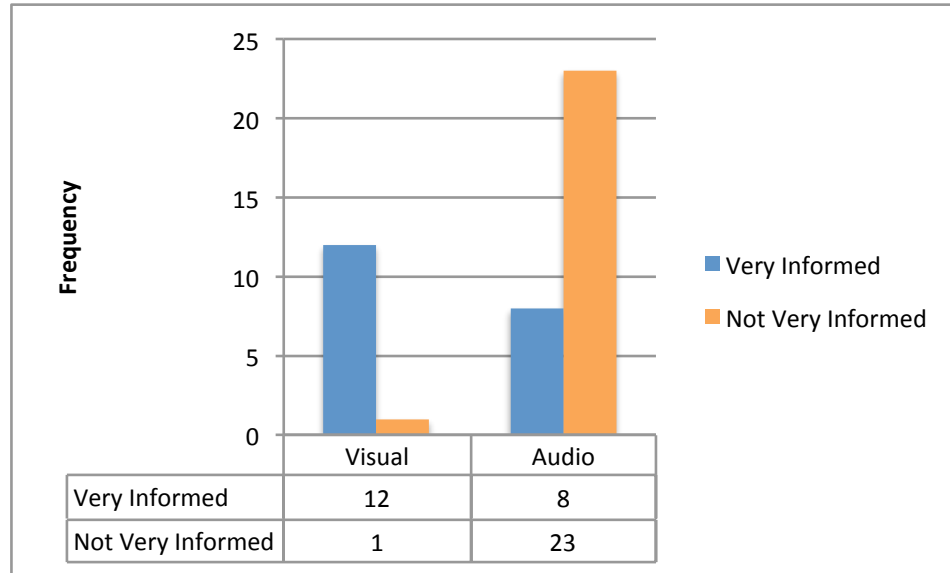


Figure 8. Perceptions on how informed patient visitors were by medical staff throughout the ED visit by modality of communication ($X^2 = 16.3$, $df=1$, $p= <0.01$). Visual mean= 84.4, audio mean= 43.6, $t = 3.7$, $df= 42$, $p= <0.01$.

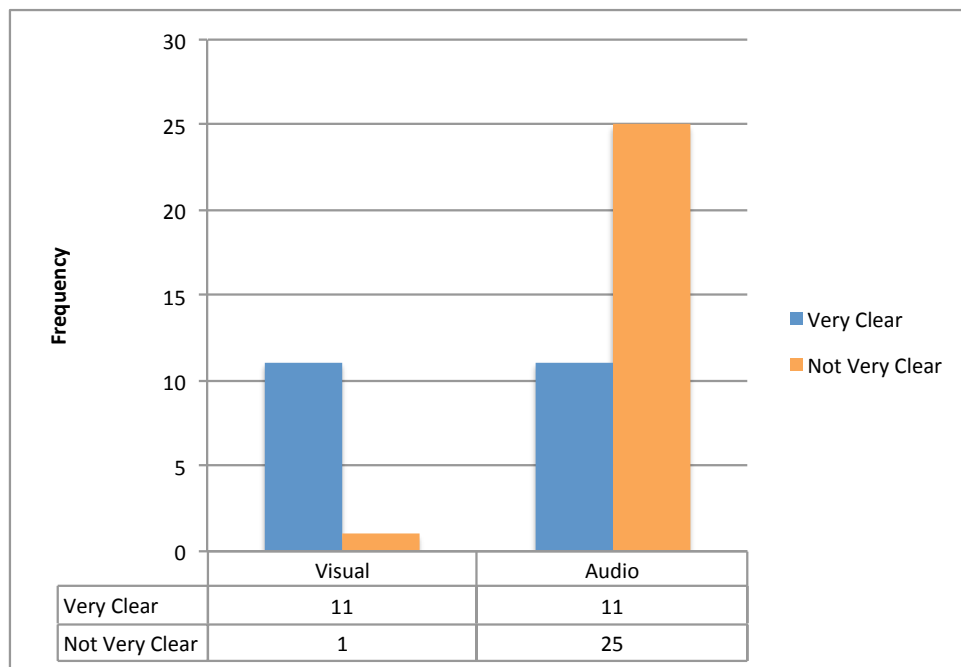


Figure 9. Perceived clarity on follow-up care instructions by modality of communication ($X^2 = 13.5$, $df=1$, $p= <0.01$). Visual mean= 94.4.6, audio mean= 39.2, $t = 9.4$, $df= 32.8$, $p= <0.01$.

A similar trend was observed when comparing visually assisted translation/interpretation services to patients who were treated by medical staff that were either bilingual or partially proficient in Spanish. Patients reported more instances of experiencing difficulties in understanding follow-up care instructions as well as their visitors feeling less informed throughout the ED visit (**Figures 10-11**) when the medical team attempted to communicate with patients. Comparing visually assisted translation/interpretation with present family members who communicated the patient’s concerns to medical staff indicated more instances of negative experiences when family members were providing the primary means of communication. This was observed in patient responses to perceived helpfulness of medical staff during the HPI, how informed patient visitors felt throughout the ED visit, and clarity in understanding follow-up care instructions (**Figures 12-14**).

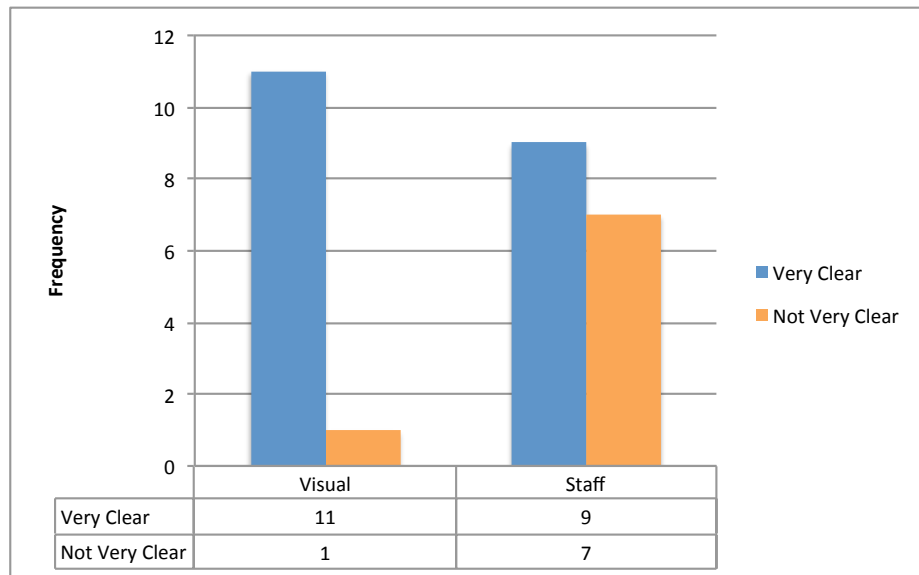


Figure 10. Perceived clarity on follow-up care instructions by modality of communication ($X^2 = 0.5$, $df=1$, $p= 0.05$). Visual mean= 94.4, staff mean= 54.5, $t= 4.9$, $df= 23.8$, $p= <0.01$.

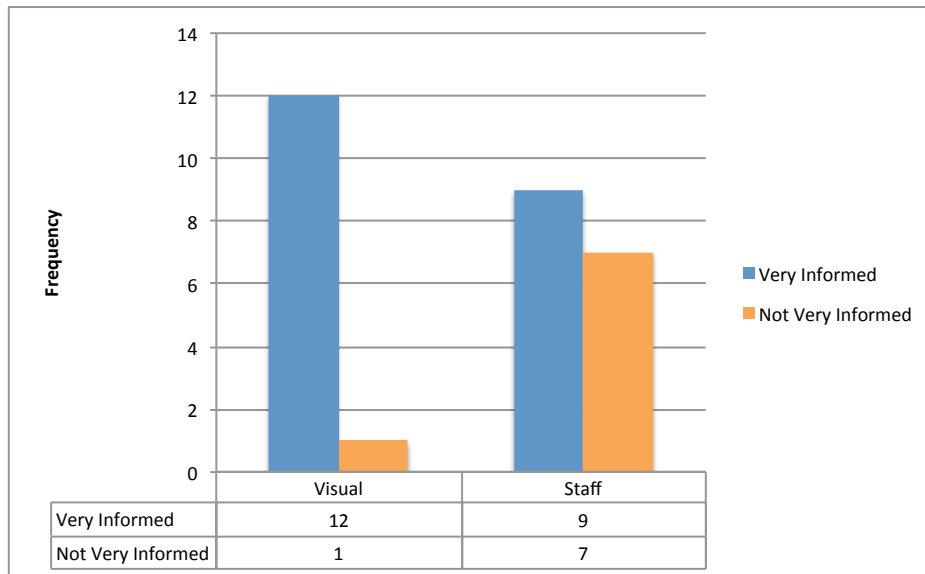


Figure 11. Perceptions of on how informed patient visitors were by medical staff throughout the ED visit by modality of communication ($X^2 = 4.7$, $df=1$, $p= 0.03$). Visual mean= 84.4, staff mean= 56.6, $t= 2.3$, $df= 27$, $p= 0.03$.

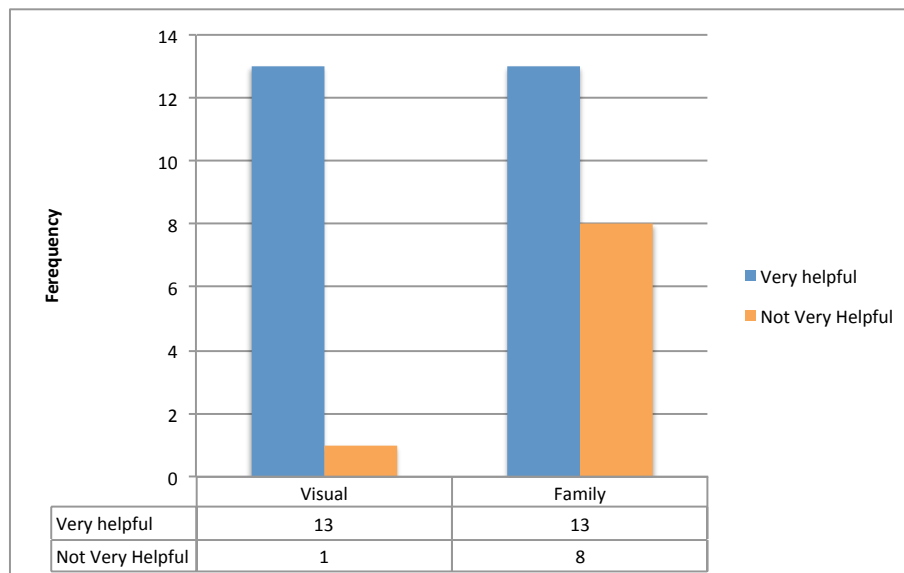


Figure 12. Perceived helpfulness of medical staff during the HPI by modality of communication ($X^2 = 4.2$, $df=1$, $p= 0.04$). Visual mean= 87.1, family mean= 65.5, $t= 2.7$, $df= 32.6$, $p= 0.01$.

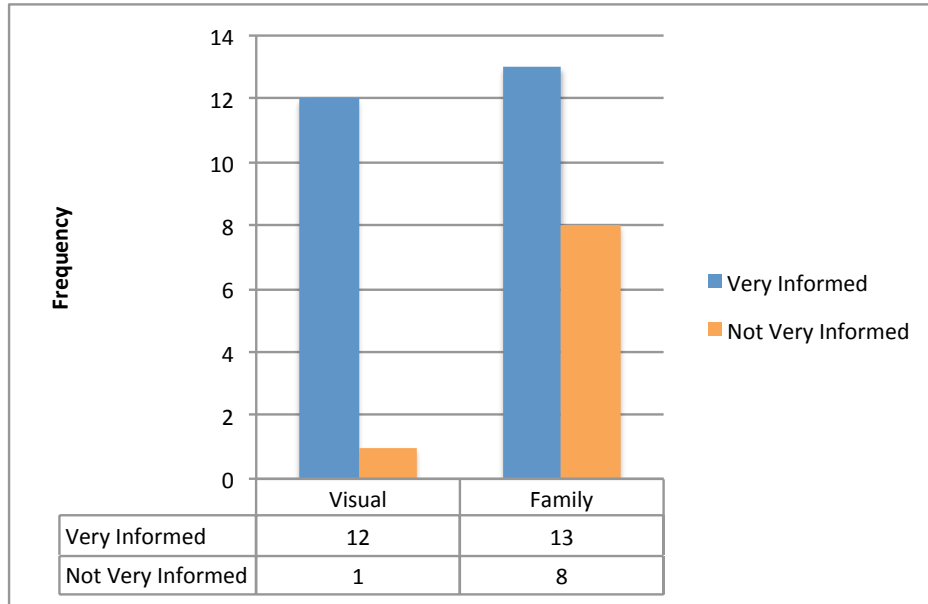


Figure 13. Perceptions of on how informed patient visitors were by medical staff throughout the ED visit by modality of communication ($X^2 = 3.8$, $df=1$, $p= 0.05$). Visual mean= 84.4, family mean= 61.3, $t= 2.0$, $df= 32$, $p= 0.05$.

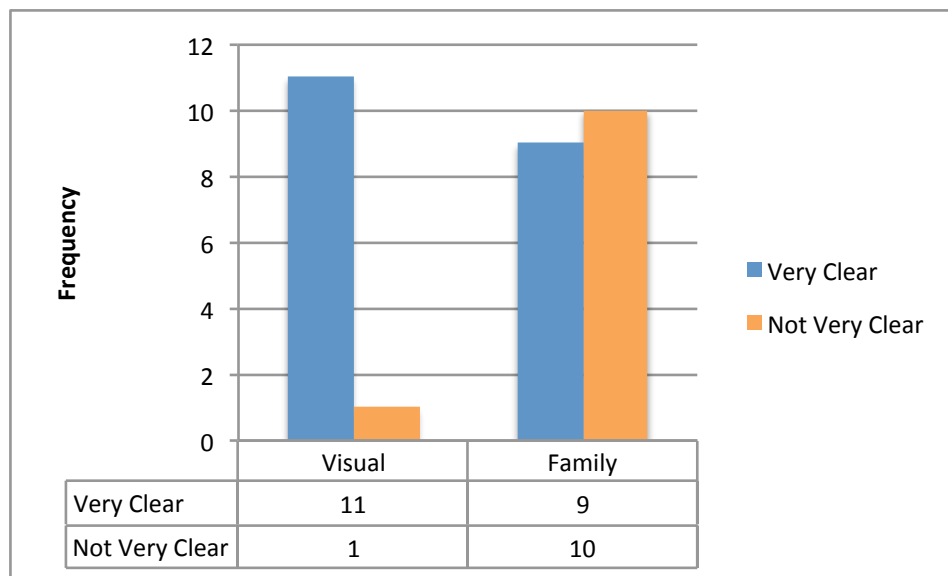


Figure 14. Perceived clarity on follow-up care instructions by modality of communication ($X^2 = 6.3$, $df=1$, $p= 0.01$). Visual mean= 94.4, family mean= 54.8, $t= 4.9$, $df= 27.8$, $p= <0.01$.

Audio-based translation/interpretation services were associated with more frequent instances of patients reporting negative experiences during their ED visit when compared to

patients who primarily communicated with bilingual or partially proficient Spanish-speaking staff. This was observed in responses to questions pertaining to how informed patients were by nursing staff during their visit, perceptions of how seriously nursing staff addressed patient concerns, and how informed patient visitors were during the visit (**Figures 15-17**). Audio-based translation also appeared to be associated with more frequently reported instances of being less informed by physicians and ED staff when compared to patients who had a family member present to provide interpretation (**Figures 18-19**). Lastly, translation/interpretation services provided by bilingual or partially proficient Spanish-speaking staff were associated with more negative experiences and lack of clarity in understanding follow-up care plans in comparison to audio based communication services (**Figures 20-21**).

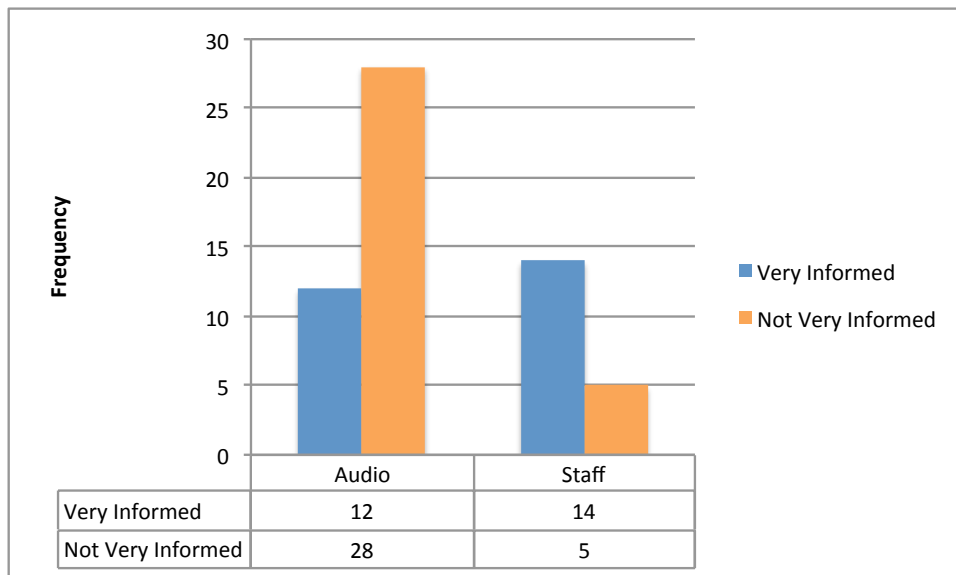


Figure 15. Patient perceptions of being informed by nursing staff throughout the ED visit by modality of communication ($X^2 = 8.3$, $df=1$, $p= 0.02$). Audio mean= 39.3, staff mean= 66.5, $t= -2.9$, $df= 57$, $p= <0.01$.

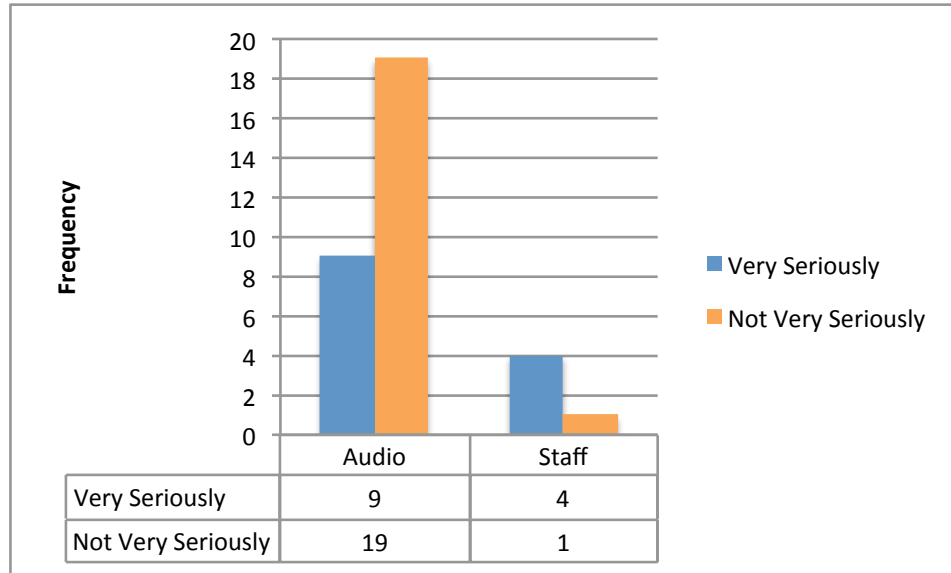


Figure 16. Patient perceptions on how seriously nursing staff addressed their concerns by modality of communication ($X^2 = 4.1$, $df=1$, $p= 0.04$). Audio mean= 61.0, staff mean= 78.0, $t= -2.5$, $df= 38.9$, $p= 0.02$.

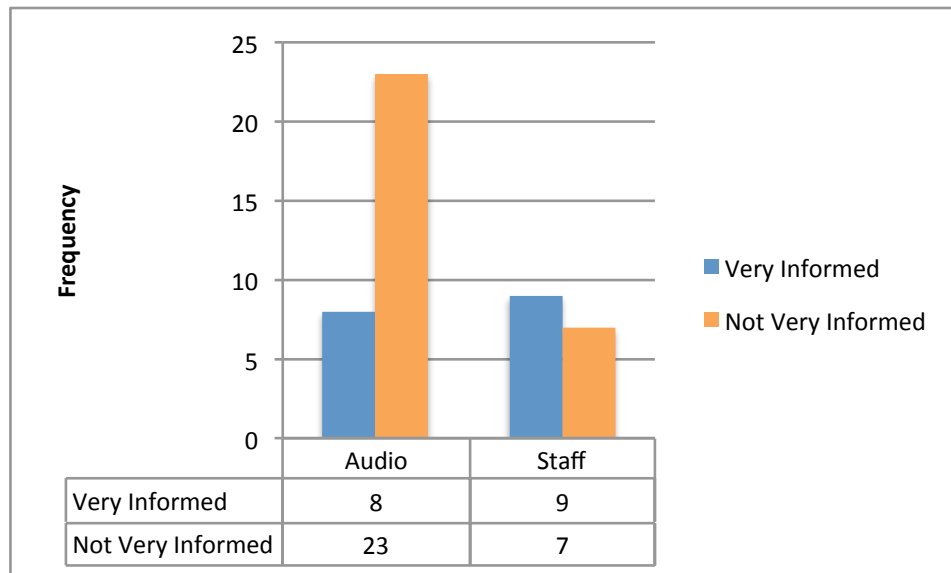


Figure 17. Perceptions of on how informed patient visitors were by medical staff throughout the ED visit by modality of communication ($X^2 = 4.2$, $df=1$, $p= 0.04$). Audio mean= 39.4, staff mean= 60.8, $t= 2.3$, $df= 46$, $p= 0.03$.

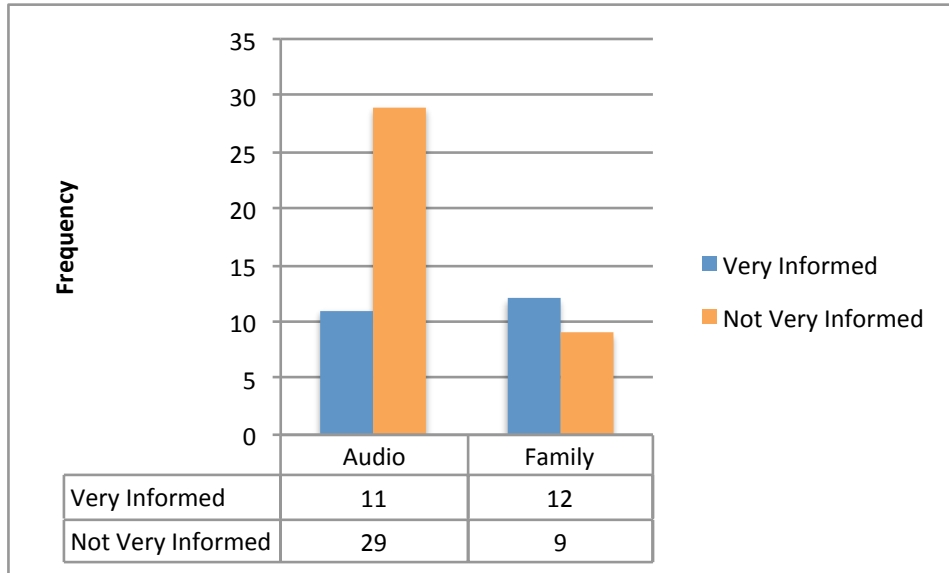


Figure 18. Perceived degree of how informed patients were by physicians throughout the ED visit by modality of communication ($X^2 = 5.2$, $df=1$, $p= 0.02$). Audio mean= 38.2, family mean= 56.3, $t= -1.9$, $df= 59$, $p= 0.06$.

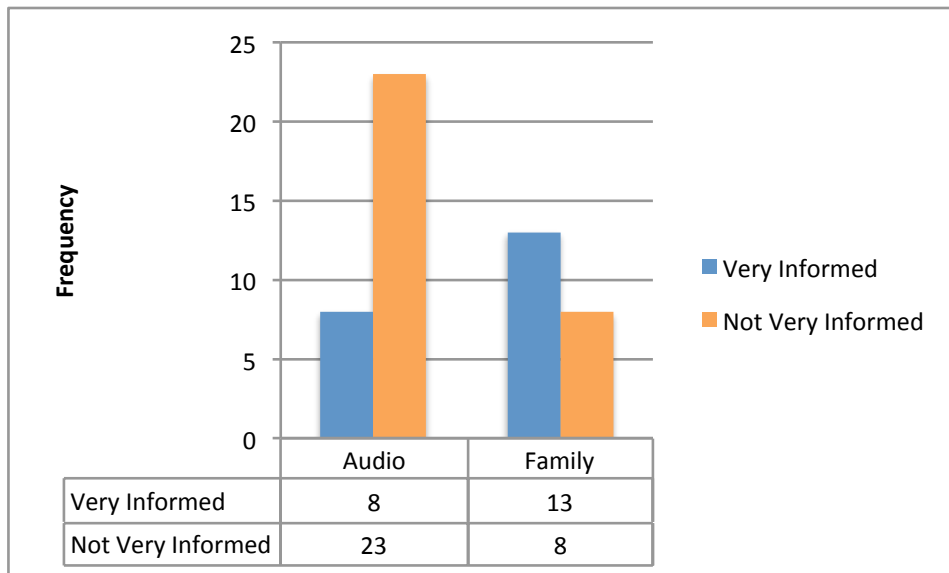


Figure 19. Perceptions of how informed patient visitors were by medical staff throughout the ED visit by modality of communication ($X^2 = 6.7$, $df=1$, $p= <0.01$). Audio mean= 43.6, family mean= 61.3, $t= -1.9$, $df= 50$, $p= 0.07$.

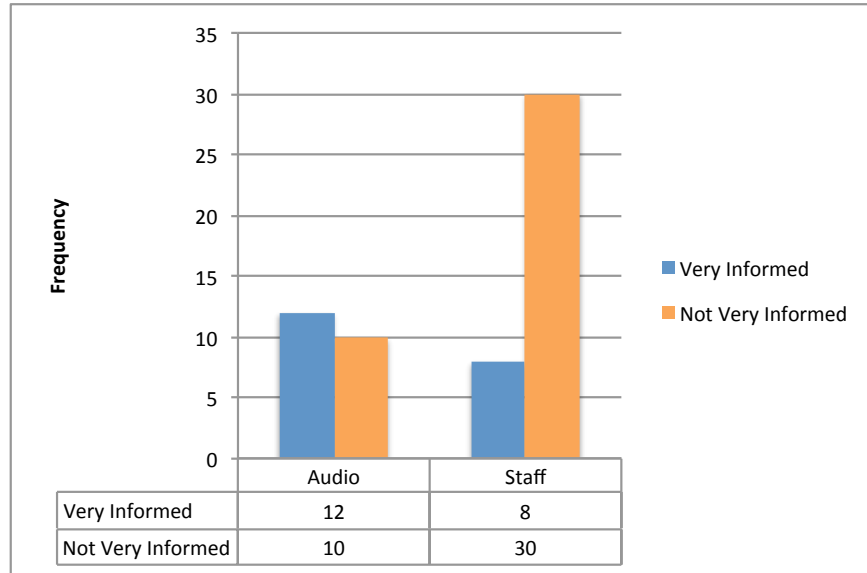


Figure 20. Perceptions of how informed patients felt by physicians at disposition by modality of communication ($X^2 = 7.0$, $df=1$, $p= <0.01$). Audio mean= 38.2, staff mean= 58.5, $t= -2.1$, $df= 57$, $p= 0.04$.

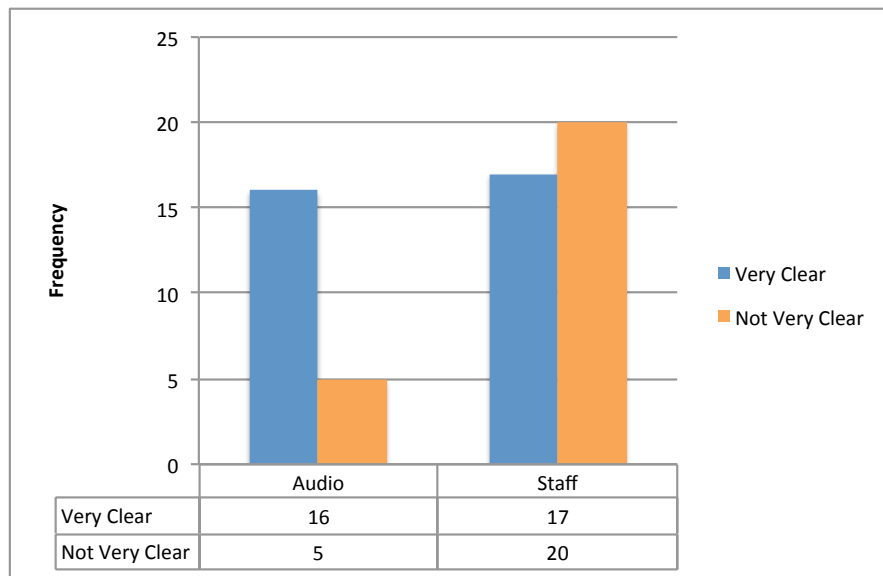


Figure 21. Patient perceptions on the degree of clarity in understanding the physician's follow-up plan at disposition by modality of communication ($X^2 = 4.9$ $df=1$, $p= 0.03$). Audio mean= 39.2, staff mean= 54.5, $t= -2.0$, $df= 50$, $p= 0.05$.

Correlation tests were conducted on the VAS responses in order to assess for relationships between the experiences of the participants. Perceptions on clarity of follow-up

care instructions were observed to be moderately positive in correlation with the amount of attention demonstrated by nursing staff, how informed patients were by nursing staff during their ED visit, how well their pain levels were controlled, overall participant ratings of their ED experience, and the likelihood of them recommending the ED at Metropolitan hospital to others (Figures 22-26).

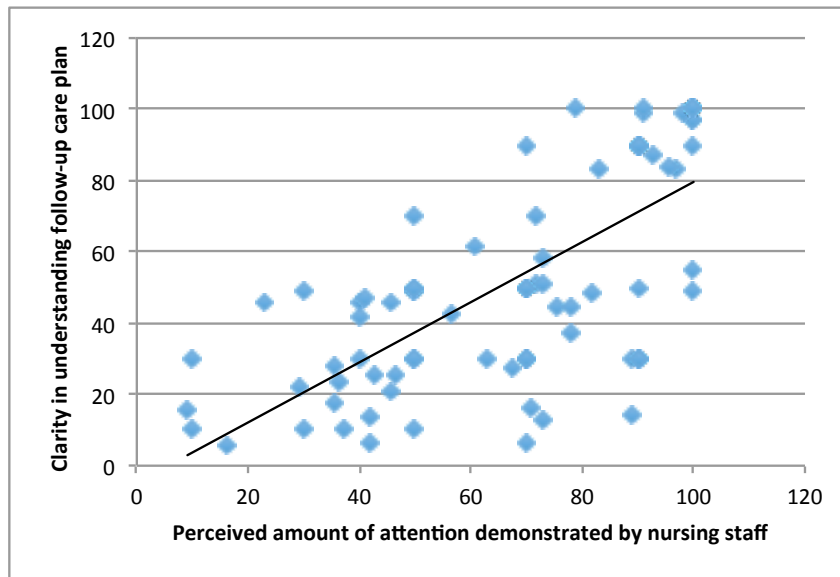


Figure 22. Scatterplot of perceived amount of attention demonstrated by nursing staff in relation to clarity in understanding follow-up care plan ($r=0.71$, $p < 0.01$).

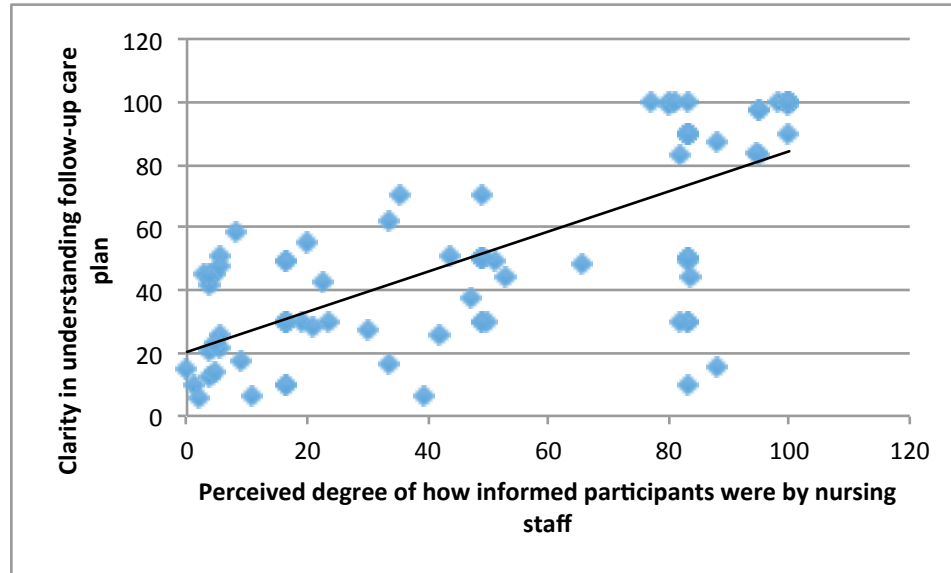


Figure 23. Scatterplot of perceived amount of attention demonstrated by nursing staff in relation to clarity in understanding follow-up care plan ($r=0.73$, $p < 0.01$).

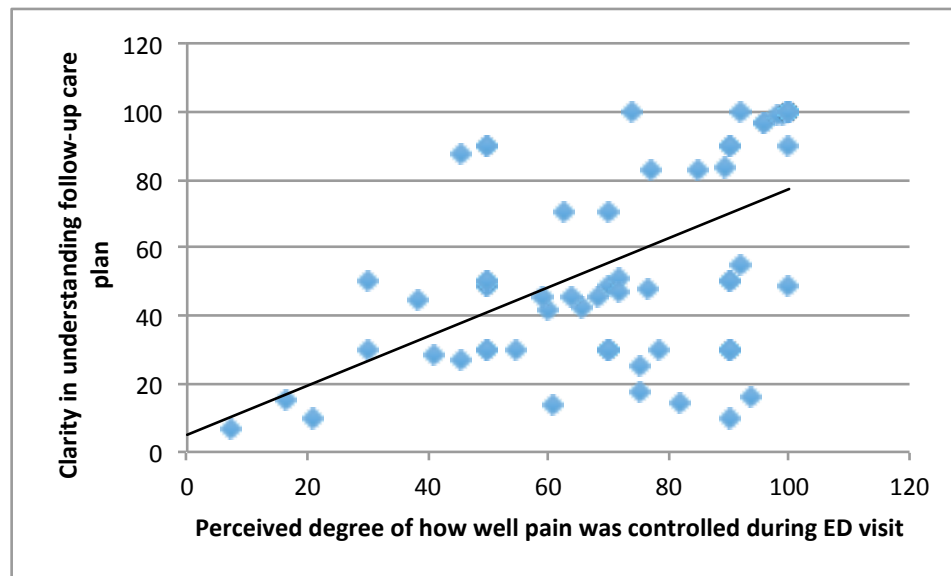


Figure 24. Scatterplot of degree of how well pain was controlled during ED visit in relation to clarity in understanding follow-up care plan ($r=0.99$, $p < 0.01$).

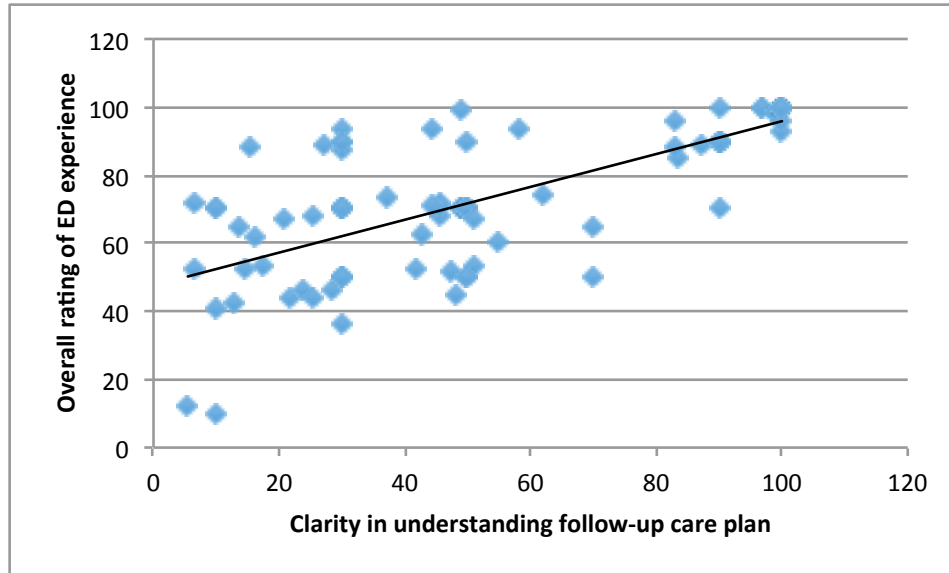


Figure 25. Scatterplot of clarity in understanding follow-up care plan in relation to overall rating of ED experience ($r=0.71$, $p= <0.01$).

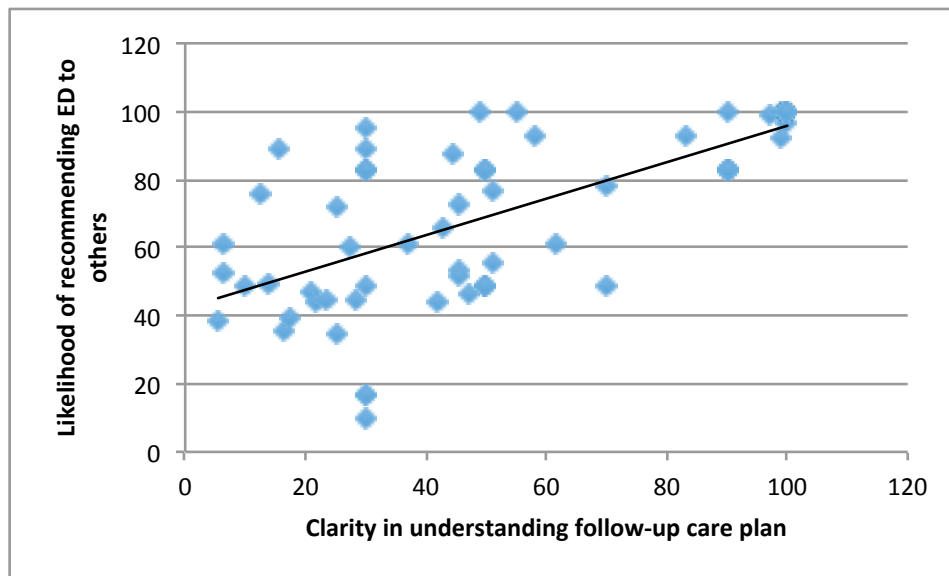


Figure 26. Scatterplot of clarity in understanding follow-up care plan in relation to likelihood in recommending ED to others ($r=0.69$, $p= <0.01$).

The perceived amount of attention demonstrated by nursing staff was found to be moderately positive in correlation to perceptions on how much the overall ED staff demonstrated caring for participants during their visit, how informed patients were throughout their visit, and how concerned nursing staff was for the privacy of participants (Figures 27-29). Moderately positive correlations were also observed between clarity in understanding physicians and the perceived amount of caring demonstrated by the overall ED staff (Figure 30).

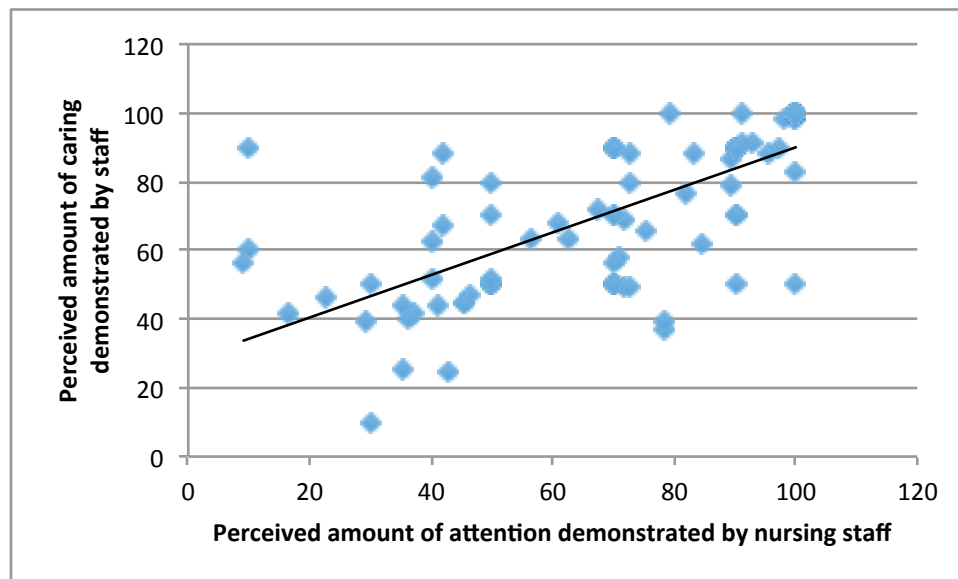


Figure 27. Scatterplot of perceived attention demonstrated by nursing staff in relation to perceived amount of caring demonstrated by overall ED staff ($r=0.71$, $p<0.01$).

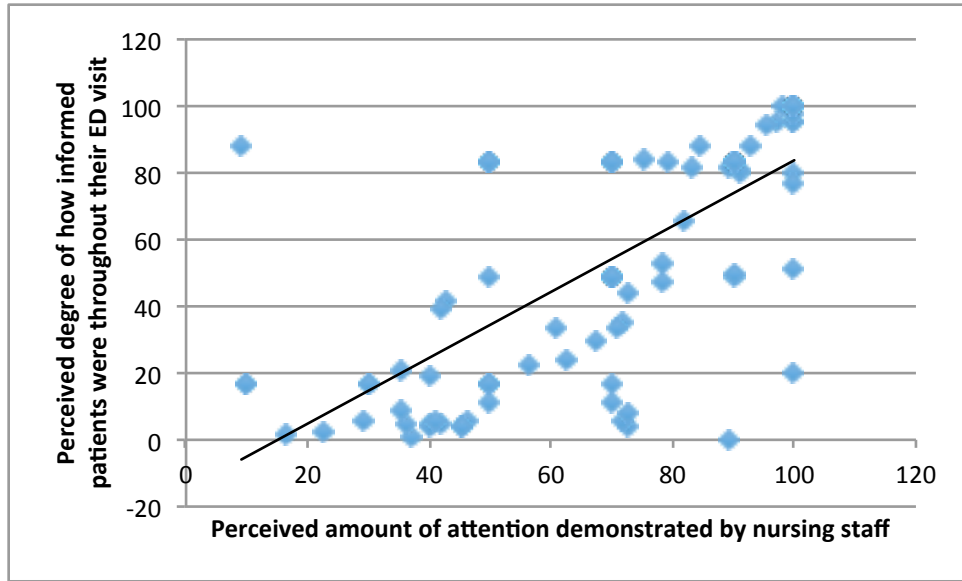


Figure 28. Scatterplot of perceived amount of attention demonstrated by nursing staff in relation to how informed patients were throughout their ED visit ($r=0.71$, $p= <0.01$).

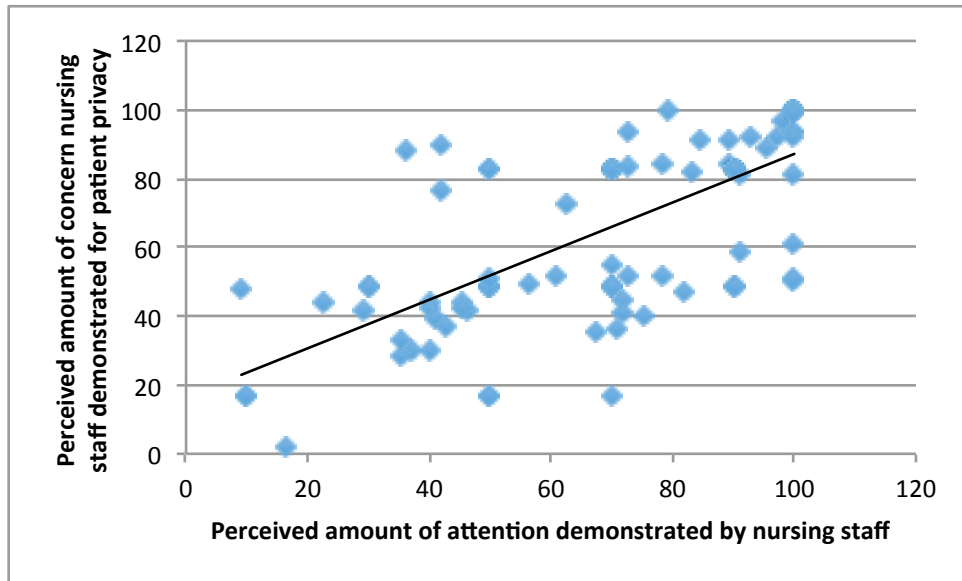


Figure 29. Scatterplot of perceived amount of attention demonstrated by nursing staff in relation to perceived amount of concern nursing staff demonstrated for patient privacy ($r=0.70$, $p= <0.01$).

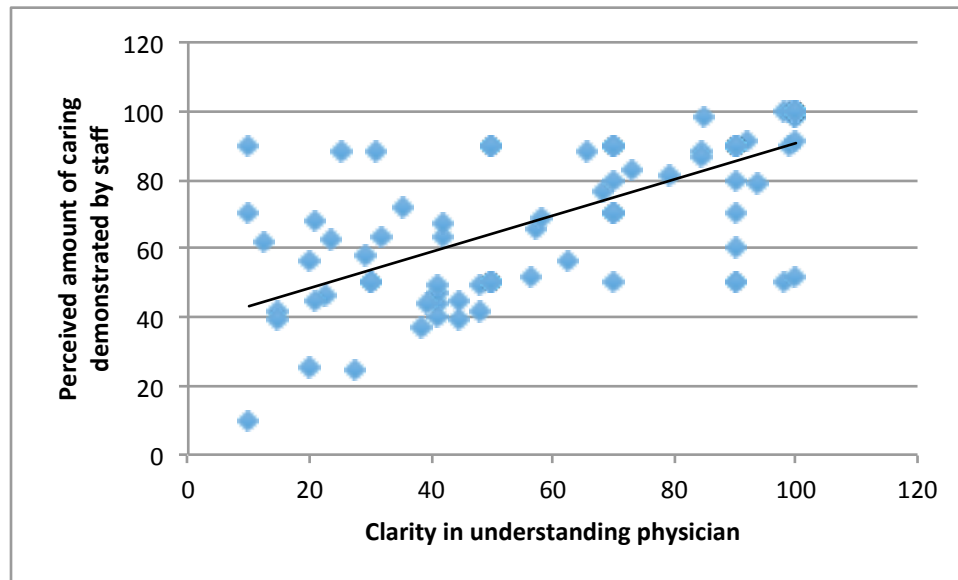


Figure 30. Scatterplot of clarity in understanding ED physician in relation to perceived amount of caring demonstrated by overall ED staff ($r=0.69$, $p= <0.01$).

Retrospective Comparison Analysis

Quantitative analysis of the modified patient satisfaction survey point to some of the unique experiences of Spanish-speaking patients in utilizing the ED for medical evaluation of non-urgent conditions. Comparison between this specific patient population and their English counterparts offers a way of holistically examining whether the experiences of Spanish-speaking patients are isolated or shared with other patient groups. Although a similar sample of English-speaking patients seeking non-urgent care was not recruited, consented, and enrolled into the study, existing patient satisfaction data collected from Metropolitan Hospital was analyzed as a way of comparing both of these patient groups. This dataset consisted of 4940 unique patient responses collected between 2012-2017. English-speaking patients represented 97% of the sample, with only a total of 129 individual responses by Spanish-speaking patients.

Visual representation of overall participant responses suggests a general trend in positive ratings from patients being treated at the Metropolitan Hospital ED (**Figure 31**). Visual representation of participant responses by language points to proportionally more positive ratings from Spanish-speaking patients for all sections of the validated patient satisfaction survey (**Figure 32**) in comparison to responses from English-speaking patients (**Figure 33**). Chi square analysis of these trends in patient responses suggests significant associations for six of the eight sections of the patient satisfaction survey (**Table 6**). These sections include positive ratings of arrival procedures, doctors, hospitality towards family and friends, how personal issues were handled in the ED, how personal insurance information was handled, and the overall patient assessment of the ED. Analysis of the average patient response rating by survey section and language additionally indicate significantly higher ratings among Spanish-speaking patients when compared to English-speaking patients (**Table 7**). Significant differences were observed in the survey sections asking patients to provide ratings of physicians overseeing their ED treatment/evaluation, how their family and friends were treated, personal issues, insurance information, and overall assessment of the ED.

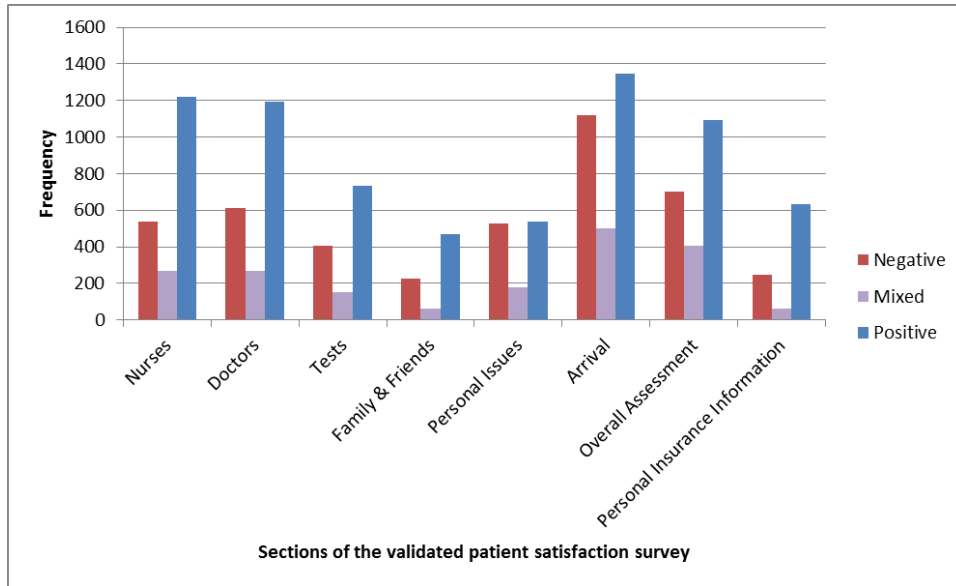


Figure 31. Distribution of all responses on a validated patient satisfaction survey returned between 2012-2017 (N=13,479*).
 (*Although the data set consisted of 4,940 unique patient responses, all patient responses were not complete in terms of assessing for all eight sections of the survey.)

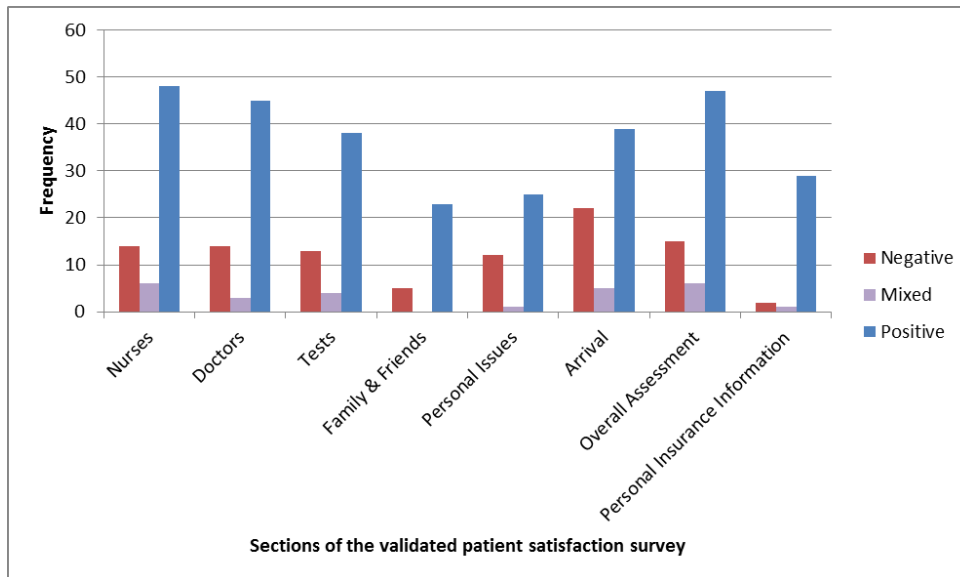


Figure 32. Sample distribution of responses submitted in Spanish on a validated patient satisfaction survey returned between 2012-2017 (n=417).

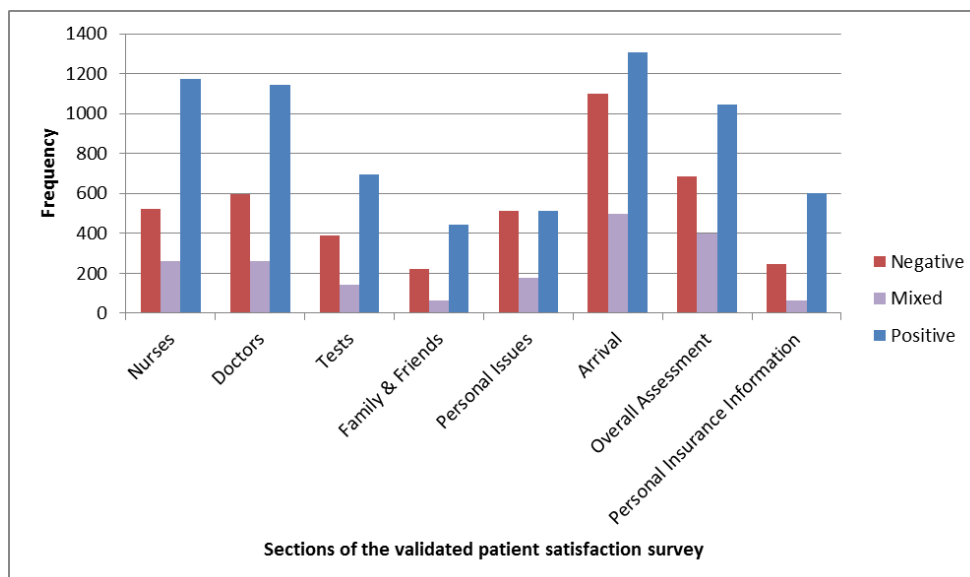


Figure 33. Sample distribution of responses submitted in English on a validated patient satisfaction survey returned between 2012-2017 (n=13,062*).

(*Although the data set consisted of 4,940 unique patient responses, all patient responses were not complete in terms of assessing for all eight sections of the survey.)

Table 6. Contingency table of responses by language, survey sections, and patient satisfaction ratings (N=13,479).

Survey Section	English			Spanish			χ^2	df	p
	Positive	Mixed	Negative	Positive	Mixed	Negative			
Nurses	1171	261	523	48	6	14	3.21	2	0.20
Doctors	1146	263	598	45	3	14	6.76	2	0.03*
Test	693	145	390	38	4	13	3.52	2	0.17
Family & Friends	445	63	220	23	0	5	5.73	2	0.05*
Personal Issues	514	179	513	25	1	12	9.41	2	0.01*
Arrival	1308	496	1097	39	5	22	6.59	2	0.03*
Overall Assessment	1046	397	685	47	6	15	10.87	2	<0.01*
Personal Insurance Information	603	62	244	29	1	2	8.36	2	0.02*

Table 7. Contingency table of responses by language, survey sections, and patient satisfaction ratings (N=13,479).

Survey Section	English		Spanish		t	df	p
	n	Mean	n	Mean			
Nurses	1955	0.33	68	0.50	-1.57	2021	0.11
Doctors	2007	0.27	62	0.50	-1.98	2067	0.04*
Test	1228	0.25	55	0.45	-1.67	1281	0.09
Family & Friends	728	0.31	28	0.64	-1.92	754	0.05*
Personal Issues	1206	0.00	38	0.34	-2.21	39	0.03*
Arrival	2901	0.07	66	0.26	-1.59	68	0.11
Overall							
Assessment	2128	0.17	68	0.47	-2.76	2194	0.01*
Personal Insurance							
Information	909	0.39	32	0.84	-2.86	939	<0.01*

Summary of Quantitative Analyses

The findings from the modified patient satisfaction survey suggest that Spanish-speaking patients report an overall positive experience when seeking non-urgent care in the ED. This is indicated by the general trend in positive ratings of the hospital and the overall high likelihood of recommending the study site to their family and friends. The survey responses broadly indicate that this patient population perceived the nursing, medical, and general ED staff to take patient concerns seriously during their hospital visit and to pay attention to their needs. This overall positive rating of the hospital is also reflected in participant responses to overall short wait times prior to being assigned a bed, pain management (among those who initially reported having pain upon presenting to the ED), and hospitality toward patient visitors while in the ED. These general positive ratings of their ED experience was quantitatively confirmed through the retrospective analysis of existing patient satisfaction data collected from Metropolitan Hospital. This analysis suggested contrasting trends in patient ratings where English-speaking patients

proportionally reported more negative experiences in comparison to Spanish-speaking patients (**Figures 32-33, Tables 6-7**).

Despite patients reporting the ED intake process and the medical team's obtaining of individual HPIs to be helpful, a general trend in survey responses was observed in patients feeling not informed or under informed by the nursing and medical staff. This relates to the general difficulties participants reported in understanding the follow-up care plans developed by the medical team. Assessing modalities of communication throughout the entire patient cohort suggest discordant uses of translation/interpretation at the beginning and at the end of the ED visit.

Multiple statistical analyses point to significant trends among patient responses. Visually assisted translation/interpretation was associated with fewer negative responses when compared to audio-based means of communication assistance (**Figures 6-9**). This same trend was observed when comparing visually assisted translation/interpretation to instances when staff (**Figures 10-11**) and family members (**Figures 12-14**) were the primary means of communication with patients. Aside from how informed patients felt by physicians at disposition (**Figure 20**) and the clarity in understanding physician follow-up plan at disposition (**Figures 21**), audio-based translation/interpretation was associated with more negative experiences in comparison to when staff (**Figures 15-17**) and family members (**Figures 18-19**) were the primary means of communication.

Several moderately positive correlations were also observed in the overall patient responses. Clarity of follow-up care instructions was associated with the amount of attention patients perceived from nursing staff ($r=0.71, p < 0.01$; **Figure 22**), how informed patients felt by nursing staff ($r=0.73, p < 0.01$; **Figure 23**), how well their pain was managed ($r=0.99, p < 0.01$;

Figure 24), overall rating of ED experience ($r=0.71, p= <0.01$; **Figure 25**), and likelihood of recommending the hospital ($r=0.69, p= <0.01$; **Figure 26**). Perceived amount of attention demonstrated by nursing staff was associated with how much the overall ED staff demonstrated caring for participants during their visit ($r=0.71, p= <0.01$; **Figure 27**), how informed patients were throughout their visit ($r=0.71, p= <0.01$; **Figure 28**), and how concerned nursing staff was for the privacy of participants ($r=0.70, p= <0.01$; **Figure 29**). Lastly, clarity in understanding physicians was found to be associated with the amount of caring demonstrated by the overall ED staff ($r=0.69, p= <0.01$; **Figure 30**).

Semi-Structured Interviews

A total of 25 patients were recruited and consented into this phase of the study by one of the research team members. The mean age of the participants was 49 and consisted of 17 females (68%) and 8 males (32%). All of the interviewed patients reported placing a high level of importance on healthcare centers, such as clinics and hospitals, having translation/interpretation services available to them. When asked to further explain their views, 36% reported that having these services available to patients facilitated their own ability to communicate with the medical staff in terms of explaining their medical problems and past medical histories. 46% of the responses to this question pertained to how these communication services facilitated patient understandings on what was actually going on in the ED in terms of why particular tests were being conducted, the status of these results, and the ability for staff to provide better explanations regarding the patients' conditions as well as follow-up care plans. The other 18% of the responses generally pertained to the avoiding of miscommunication between patients and

medical staff when translation/interpretation services were used. Some of their statements included the following:

Maybe I need to learn English instead since we are in a country where the main language is English. It makes it a lot easier to be able to tell them exactly what symptoms you are feeling. – 52 year-old man.

My health is important and I want to know clearly what is wrong with me. – 46 year-old woman.

Being able to communicate is important so they can understand your health problems but also so you can understand what is going on. – 33 year-old woman.

I have a long medical history and want to be sure that whoever is treating me knows exactly what is going on so they could make the best treatment decision possible. You get scared when you feel like you can't explain everything. – 60 year-old woman.

A majority of participants (81%) expressed similar responses when asked how translation/interpretation services would improve their overall experience while receiving care in the ED. Thirteen of the 25 participants stated that being able to communicate with the medical staff made the entire ED experience less complicated because it was easier to understand the status of their care, diagnostics exams, and more importantly, what staff was explaining to them throughout their care. Twelve of the 25 participants expressed that having translation/interpretation services available when they sought out care in the ED allowed staff to understand their needs better, avoided frustrations in communication in terms of explaining their symptoms or concerns the wrong way.

All of the interviewed patients described negative sentiments whenever they were not able to completely communicate with the medical team. The most frequently reported sentiment by participants was feelings of frustration (63%), followed by feeling uncomfortable (29%) while receiving care in the ED. Some examples include:

It makes me sad because it makes me feel dumb when you can't explain everything. – 41 year-old male

It is horrible that you want to say something and you can't. – 65 year-old woman.

I am a patient with many problems and they are hard to keep up with. Imagine how hard it is to communicate that to them. – 60 year-old woman.

It feels frustrating and it would be better if I could speak directly to staff because I could say exactly what I need to say. – 52 year-old man.

Not everything that I want to say is said. – 63 year-old woman.

Participants reported having used different means of communication when they sought out healthcare services in the ED. These means of communications included family members (13%), medical staff that were either bilingual or partially proficient in Spanish (68%), or an audio-based translation/interpretation service such as the blue phone (13%). Varying perspectives were expressed by participants in describing their experiences with certain modalities of communication, as is evident in the following.

A family member usually translates for me but sometimes there are things you want to explain that are personal so I don't want them to translate for me. – 31 year-old woman.

The staff tries their best to communicate with you by using whatever Spanish words they know. Although I don't think they necessarily understand everything I tried to explain to them, I appreciate their efforts to help me. – 32 year-old man.

The doctor spoke some Spanish so it was helpful to talk directly to him even if she couldn't say everything exactly. – 63 year-old woman.

Participants reported different decision-making processes in determining when to seek care in the ED. Twenty-six percent of the responses pertained to participants waiting to present to the ED when their symptoms worsened and they could no longer handle the pain associated with their symptoms. Thirteen percent of the participants reported first consulting with an outpatient healthcare center, such as a clinic or a primary care physician, regarding their

symptoms prior to presenting to the ED for evaluation. A majority (78%) of patients reported primarily receiving their care in a hospital setting, where 29% additionally reported first consulting with their family members in deciding the appropriate time to go for medical evaluation in the ED. Thirty-two percent of the participants reported presenting to the ED right away upon developing their symptoms. These responses ranged from not knowing what other healthcare services they could have sought elsewhere in order to have their symptoms evaluated to the high value of care perceived to be received in the hospital versus outpatient setting.

You just tolerate it. When the pain gets to the point where you can't do the everyday things like go to work or help around the house, that's when you come here to get checked out. – 48 year-old man.

My family can tell when I am not acting like myself so that is when I go[to seek care]. – 54 year-old woman.

At the end of visit all they tell you is that they hope you feel better and to come back if the symptoms come back or worsen. So that is what we do. We come back because where else are we going to go to be seen? – 32 year-old man.

It is better to go to the hospital than the doctor's office because you leave healthy right away. – 63 year-old woman.

Participants generally reported difficulties in understanding different aspects of their ED care and communicating with ED staff (35%). This included some of the medical terms used by ED staff, diagnostic exams being conducted, wait times for results, and follow-up care plans. Only 13% of the participant responses suggested that communicating their concerns to the medical team (via either bilingual staff or translation/interpretation services) was easy. Fifty-two percent of the participants reported being able to partially communicate with the medical team while also reporting difficulties in understanding what was going on with their ED care.

Everything was hard. The nurses did not understand what I was trying to say. – 60 year-old woman.

They come in and tell you something quickly. You just say 'OK', and then you try to figure out what they were really telling you. – 30 year-old woman.

After they ask you the questions in the beginning, you just sit here and wait. You worry more when you can't understand what is happening. I'd feel better if someone could use a translation service, like when I arrived, to explain things to me. – 29 year-old man.

Lastly, a majority of the participant responses (81%) suggested an overall positive experience in the ED. When asked to describe their overall experience, 64% reported feeling as though they received great care in the ED and another 16% reported that they appreciated the staff's efforts in finding a way to help them.

Even though I do not speak English, the staff always finds a way to help me. – 33 year-old woman.

It was good but communication was difficult. – 60 year-old woman.

I can't complain. They do their best to help, even if they can't understand me. It's us that have to do a better job at understanding them by learning English. – 31 year-old man.

Summary of Semi-Structured Interviews

Semi-structured interviews with participants suggested an overall high level of importance placed on receiving care in the patient's primary language. Participants in this phase of the study reported that being able to communicate with the medical team facilitated the ability to fully explain their symptoms and their relevant past medical histories. Responses in the semi-structured interviews additionally suggested patient concerns in being thorough with the medical personnel overseeing their care. These perspectives relate to participant descriptions of frustrations and feeling uncomfortable when not being able to communicate with medical personnel. Participant responses during the semi-structured interviews additionally point to issues surrounding confidentiality and patient autonomy, especially when using family members

to communicate their symptoms such as the case of the 31 year-old woman experiencing gynecological issues for which her son was the primary means of communication. This relates to some of the findings from the first phase of the study, where full patient autonomy was not exercised as a result of being unable to fully communicate with medical staff (see Vignette 4).

Most of the interviewed patients reported primarily receiving healthcare services in a hospital versus outpatient settings, with only a few of them first reporting consulting as an outpatient prior to coming the ED for medical evaluation. Family members appeared to be another influential factor in deciding when to present to the ED for medical evaluation. While most patients indicated that having available translation/interpretation services in healthcare settings would overall improve their experiences in seeking care, the majority still reported overall positive experienced when seeking non-urgent care in the ED.

CHAPTER 6: DISCUSSION & CONCLUSIONS

The chapter contextualizes the results from this exploratory, mixed-methods study. The first section addresses how the findings develop an argument in understanding language as a unique social determinant of health (SDH), especially among Spanish-speaking patients. The second section draws from study findings to discuss patient satisfaction in terms of their relevance to providing non-urgent care in ED settings to this specific patient population. The final section discusses the scholarly contributions the study and findings offer to the biomedical and social sciences with an emphasis on how both fields can complement each other in studying some of the issues that are particular to special patient populations.

Language as a Social Determinant of Health

Examining the data collected via participant observation and patient shadowing as well as responses during the semi-structured interviews suggest that the patients and medical personnel in this study had aligning explanatory models. This is say that both parties referenced and relied on Western biomedical understandings of health and illness with respects to attempting to discern the cause(s) of patient health conditions. This appears in several of the ethnographic clinical vignettes in the ways participants described their conditions, their thoughts on why they were experiencing particular symptoms, and actions taken to treat or manage their symptoms prior to presenting to the ED for medical evaluation. Responses to the semi-structured interviews also revealed similar sentiments, where several participants expressed concerns over not being

able to fully describe their symptoms and communicate their past medical histories to the personnel overseeing their care as a result of the modalities of translation/interpretation and other language barriers present during their ED visits.

The second and third ethnomedical aspects of explanatory models (methods of diagnoses and the development of therapeutic interventions or follow-up care plans) seem to be the diverging point between the participants and the medical personnel overseeing their care. Findings from the modified patient satisfaction survey and statistical analyses suggest that staying informed throughout the ED visit, understanding the medical team, as well as understanding follow-up care plans and possible steps to take as an outpatient to manage their symptoms or conditions was reported to be very important to the participants. In this same vein, participants generally reported feeling uninformed or under-informed while they received care and expressed lack of clarity in understanding personnel as well as the follow-up care plans developed for them. Modality of communication with patients appeared to be implicated in these sentiments. Reviewing some of the ethnographic and qualitative data collected indicate a general disproportionate emphasis by medical personnel on the diagnostics aspects of the visit over effective communication about possible therapeutic interventions and continued care. An example of this can be observed in the lack of consistency in the use of translation/interpretation modalities between intake and obtaining of patients' histories of present illness (HPI) to disposition. This can be partly explained by prioritization from emergency physicians to diagnose anatomophysiological dysfunctions defined by known organic pathologies as a way to understand patient symptoms. Over-emphasis on the diagnostic aspects of clinical care and lack of comprehensive explanations to patients at disposition could explain why many of participants expressed feeling underinformed or uninformed on their follow-up care plan and treatment.

Examining the explanatory models among participant responses and experiences in the ED simultaneously reveals how health literacy is an important concept to consider in the care and needs of this special patient population. Drawing from the four domains of Sørensen's (2012) Health Literacy Model (access, understand, appraise, and apply), the participants reported attempting to access information and further medical evaluation for their symptoms and conditions prior to presenting to the ED. As previously discussed, participants generally reported difficulties in understanding the medical staff linguistically as a result of the existing language barriers and in terms of comprehending their outpatient treatment and continued care plans. In other words, the content, amount, and clarity of information provided at the end of the ED visits were the point where most uncertainties were expressed by participants. This directly ties into the appraisal domain of Sørensen's Health Literacy Model, which emerged in participant responses regarding lack of clarity in their continued care plans with regards to where to go for follow-up, which over-the-counter medications they could use at home, how to be prescribed medications as an outpatient, and determining when to seek further medical attention. *"If anything gets worse, please come back to the ED"*. This is a very common and routine statement expressed by medical staff upon discharging patients and when combined with the apply domain, explains why the primary source for medical evaluation among this patient population is an inpatient setting. Patient responses and reported health seeking behaviors indicate just that, where they come back to the hospital for further evaluation not just for when they perceive their symptoms to worsen, but also for evaluation of any future health-related complications.

A common thread across the results from all three phases of this study is how language can be understood to be a distinct social determinant of health (SDH). This is because language occupies a unique space among the influential social factors that determine the

vulnerability of particular groups to health-compromising states or conditions. By health-compromising states or conditions, I do not refer to just acute or emergent medical situations, but also chronic health conditions and long-term management of health that is not temporally fixed. While language is certainly implicated among other social factors that determine health such as race/ethnicity, social class, education, and in some ways, socioeconomic status; it serves as a crucial medium by which individuals access, acquire, understand, and appraise health information in order to apply it when determining when and how to seek healthcare services and medical evaluation. This is important to consider within a monolingual context, which in turn raises questions regarding how language influences health-compromising states or conditions in multilingual contexts such as that of the participants in this study.

Trivializing Patient Satisfaction

Examining language reveals several issues that can be investigated through the use of health-related deservingness as a conceptual framework. The clinical ethnographic vignettes presented here delineate differing ways Spanish-speaking patients who sought out non-urgent care perceived, understood, and interpreted their rights to receive medical evaluation in their primary language. The opening vignette in Chapter 1 captures Marcos' mixed sentiments of self-frustration, self-blame in not being able to fully communicate and understand the medical team, empathy for the medical team not knowing Spanish, and deep gratitude for any form medical attention offered to him. These complex sentiments continually arose in participant responses throughout fieldwork in the ED, evident in Yamaira and Natalia's experiences in Chapter 5. Here, participants self-gauge their deservingness to healthcare services based on their own abilities to communicate with the medical personnel providing the care. This begins to ethnographically

delineate why some of the participants repeatedly expressed sentiments of gratitude and overall satisfaction with care received in the ED (suggested by the overall reported positive ratings of Metropolitan Hospital and high likelihoods of recommending the hospital to others), despite additionally reporting difficulties in communication throughout their visit. Overall high degrees of patient satisfaction were additionally confirmed through retrospective analysis of patient satisfaction data between 2012-2017. Spanish-speaking patients were found to have significantly higher levels of satisfaction of the care they received while in the ED in comparison to their English-speaking counterparts.

Utilizing the conceptual lens of health-related deservingness also elucidates how the premise of patient satisfaction should be reconsidered among this special patient population. As detailed in the review of the existing research within biomedicine and public health (Bagchi et al. 2011, Press 1997), the concept of patient satisfaction inherently implies an idea of choice that among this patient population can be considered inconsequential when understanding that the ED may be one of their only options in receiving healthcare services. This sentiment of not knowing alternative clinical spaces where they could go for medical evaluation of their symptoms was observed in responses during participant observations and patient shadowing, as well as in the semi-structured interviews. Ethnographic examination offers a potential explanation on why participants in this study expressed complex and, at times, conflicting sentiments of their deservingness to healthcare services. This conceptual approach additionally highlights some of inherent power dynamics Spanish-speaking patients experience when seeking non-urgent care in EDs. These power dynamics materialize in participant responses during expressed sentiments of gratitude for the medical attention provided during their stay in the ED and strong trust of personnel in determining the best treatment plans and courses of action for their symptoms.

These sentiments persisted despite the overall response of feeling uninformed or unclear about their continued care plans. Recognizing these power dynamics further bolsters the argument of considering language to be a distinct SDH, because of its additional function of serving as a medium that allows a dominant group (in this case English-speaking medical personnel and translators/interpreters) to have power over and power to determine health-decision making of Spanish-speaking patients.

Scholarly Contributions

This study builds from the existing body of scholarly work within medicine and public health in contributing an anthropological perspective on understanding how language influences patient satisfaction, health literacy, and the overall experience of receiving non-urgent care in an ED setting. First and foremost, participants in the study appeared to align with the explanatory models of the medical personnel overseeing their care, which provides important insight on how this patient population interprets and understands health information. Second, the results of this study continue the dialogue within academic medical circles with regards to discussions on which modalities of communication should be utilized in clinical practice when treating Spanish-speaking patients (Lion et al. 2015, Jacobs, Fu, and Rathouz 2012, Flores et al. 2012, Crossman et al. 2010, Locatis et al. 2010, Diamond and Reuland 2009, Diamond et al. 2009, Gany, Kapelusznik, et al. 2007, Brach, Fraser, and Paez 2005, Flores 2005). Type and consistency of communication modality throughout the ED visit can explain differences among patient experiences and comprehension. Type of communication modality is implicated when considering that medical translation/interpretation requiring a form of technology assistance (e.g. visual and audio) is associated with less frequent reporting of issues in understanding medical

personnel when compared to instances when staff or family members are the primary means of communication. Consistency of communication modality is implicated when considering that no singular form of translation/interpretation was utilized by medical staff throughout an individual patient's visit, adding to the variability of the experiences of Spanish-speaking patients as well as their comprehension of discharge instructions and follow-up care plans. Study findings suggest that type and consistency of communication modality are factors that deserve additional consideration within scholarly dialogue, which predominantly assume a consistent use of translation modality within each study's participant population and is not the case in actual clinical practice (Jacobs, Fu, and Rathouz 2012, Bagchi et al. 2011, Crossman et al. 2010, Locatis et al. 2010, Gany, Leng, et al. 2007).

Qualitative and quantitative analyses did not suggest that the type of communication modalities used throughout an ED visit influenced patient satisfaction. These findings continue the dialogue within academic literature in debating which modalities of communication are associated with improved patient satisfaction metrics (Bagchi et al. 2011, Ngui and Flores 2006, Halfon et al. 2004, Garcia et al. 2004, Lee et al. 2002, Carrasquillo et al. 1999, Betz Brown et al. 1999, Kuo and Fagan 1999, Baker, Hayes, and Fortier 1998). The findings from this study additionally call for reconsidering the use of the satisfaction paradigm when it comes to studying special patient populations and instead draw from the conceptual orientations of SDH, health-related deservingness, and health literacy. As outlined, reviewed, and discussed in Chapter 2, the satisfaction paradigm appears to be inconsequential among special patient populations because it assumes the idea of choice that can be trivial due to fact that EDs may be one of their only options, if not the sole means, of receiving healthcare services. The triviality of a patient satisfaction framework does not address some of the contextual issues that influence patient

decisions of seeking non-urgent care in the first place. These types of analyses were made possible through the mixed-methods and ethnographic approach utilized in this study, which introduces new methodological contributions with scholarly work in the social and biomedical literature focused on Spanish-speaking patients and non-urgent health seeking behaviors. From the perspectives of clinically applied anthropology, this study also offers insights on how ethnographic work can be carried out in institutionalized clinical spaces.

Applications of Findings and Recommendations

The findings from this study offer several points of applications in clinical practice for medical personnel that treat Spanish-speaking patients. Analyses of the modified patient satisfaction survey suggest disproportionate uses of communication modalities by the medical team. The first application of these findings would be for staff to consistently use a modality of communication with Spanish-speaking patients, preferably one that does not involve visiting family members or friends as the primary means of translation. Modality of communication that was facilitated using visual or audio based technology appeared to be associated with fewer instances of patients reporting feeling uninformed or lacking clarity on continued care instructions and higher instances when bilingual or partially proficient Spanish-speaking staff were the primary means of communication. In this same vein, if family members or visiting friends are the only available modality of communication, it is important to remember to communicate directly with the patient rather than their translator/interpreter in place of the patient. Ethnographic data collected in this study highlight some of the inherent power dynamics already present between ED personnel and patients, as well as how these dynamics become magnified when their translator/interpreter is a family member or friend.

The correlation test results from participants begin to indicate which members of an ED team can be the most effective points of intervention in improving patient experiences and understandings. Participants in this study correlated the amounts of attention they perceived nursing staff demonstrated to the amount of concern for patient privacy, how informed they felt throughout their ED visit, clarity in understanding follow-up care plans, and the perceived amount of attention demonstrated by the ED staff overall. The degree of how informed participants felt by nursing staff was also correlated with the reported clarity in understanding continued care plan instructions. These findings indicate that nursing staff education on their importance to overall patient experience and comprehension (especially among Spanish-speaking patient populations) should be institutional priorities set in place by ED and hospital administrators. Professional development opportunities for this group of ED personnel pertaining to practical strategies on effective communication practices with Spanish-speaking patients could be a point of intervention in addressing the needs of this patient population and contribute to their improved health outcomes. Professional development for physicians additionally presents another opportunity of intervention in simultaneously improving the experiences and understanding of this patient population when considering that participant responses indicated a fairly positive significant correlation between the perceived degree of clarity in understanding physicians and the perceived amount of caring demonstrated by the overall ED staff. Professional development strategies for all of these ED staff also offers a way of integrating some of the ethnographic and qualitative findings as a way of further contextualizing the experiences of Spanish-speaking patients. Examples of these professional development strategies could include workshops and in-services where these research findings could be shared with the entire ED staff.

The final application from the results of this study is establishing ED-based efforts that focus on patient education, specifically during the disposition part of the visit. These efforts could be through linguistic and reading level appropriate reading approaches, such as having ancillary and support staff members (e.g., social work staff) thoroughly explain discharge instructions and continued care plans to patients in a manner that ensures patient comprehension. While having physicians and nurses take on these responsibilities may be ideal, this may not be the most feasible in actual practice when considering all of the responsibilities of these ED personnel. This type of intervention should specifically inform Spanish-speaking patients about how to go about managing their symptoms or conditions at home, how to determine when to seek reevaluation, and where the best pre-ED care options can be accessed.

Limitations and Points of Departure

Although this study offers insights in understanding how Spanish-speaking patients experience seeking non-urgent care in ED settings, certain research limitations are worth noting upon reflection. To begin with, this study was conducted in one ED in a single urban metropolitan setting. This limits the generalizability of the findings across Spanish-speaking populations in different urban metropolitan counties or rural areas. In terms of research design, certain variables were not included in the design of the modified patient satisfaction survey or the semi-structured interviews. Participant insurance coverage was not asked as a way of minimizing intimidation in part of the research team and maximizing rapport with consented participants. Measures for English-language literacy were additionally not included in the design of either research tool when considering that medical evaluation in the ED do not specifically ask for patients level of education during any part of a hospital visit. Additionally, this variable would be better suited in

applying it to a more homogenous patient population either in terms of groups from specific geographic locations in the surrounding communities and/or ethnicities. In the case of the participants in this study, common factors included preference of speaking Spanish as a first language, being at least 18 years of age, and presenting to the ED for a non-urgent condition determined at triage. Including both of these dependent variables in future research could offer more demographic insights on the ways they can influence or drive some of the topics explored in this study.

Another limitation of this study was the inherent variability in categorizing staff as a modality of communication with Spanish-speaking patients. This is to say that not all members of the ED staff that communicated with the consented patients were functionally fluent in medical Spanish. Some of the staff that provided translation/interpretation were either bilingual, partially proficient in conversational Spanish, or fluent in Spanish but not a member of the clinical aspects of patient care with limited medical knowledge (such as registration personnel or janitorial staff). Although staff was grouped together for the purposes of analysis, future studies can specifically examine the impact of differing conversational and medical Spanish on patient health literacy and satisfaction.

From a methodological standpoint, the data collection approaches to patient shadowing and semi-structured interviews could have been facilitated through the use of audio recording devices. This approach would have made the process of documenting patient responses easier and allow for interactions between the researcher and participants to be more fluid and organic. This approach would additionally offer a different way of interpreting participant responses through the use of content analysis. Although this approach would have its own set of ethical issues to

take into consideration (such as how to de-identify participant personal and medical information), it has the potential to provide richer ethnographic and qualitative data.

This study contributes to the limited body of work within biomedical and social scientific literature in ethnographically understanding the experiences of special patient populations in emergency care settings. Some points of departure in continuing this line of work include more ethnographic studies from within emergency medicine that capture the experiences of particular patient communities. Here, patient communities can be understood in ethnic terms (transnational neighborhoods, refugee groups), patients from communities in similar geographic areas within counties serviced by a particular ED (areas of regional poverty versus areas of high incidence of particular conditions), or patients with other linguistic preferences that frequently interact with a particular ED. These approaches can begin to offer ethnographic insights on how some health issues can be addressed in ED settings, which is a common clinical space of initial and frequent encounters among certain special patient populations.

Conclusions

The findings from this study delineated unique insights on the experiences of Spanish-speaking patients when they seek non-urgent care in the ED settings. The results suggest that this patient population has aligning explanatory models with ED personnel, which elucidates pertinent information in designing interventions among this group of patients. Ethnographic data additionally offer insights on some of the experiences common among this patient population that would not necessarily be identified through only using quantitative approaches that predominantly rely on satisfaction-based analyses. This study contributes to a limited body of

work that specifically draws from mixed methodologies and anthropologically informed approaches in documenting the needs and experiences of special patient populations.

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APPENDIX A: IRB APPROVAL LETTER



RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX (813) 974-7091

February 22, 2017

Seiichi Villalona
Anthropology
Tampa, FL 33612

RE: **Expedited Approval for Initial Review**
IRB#: Pro00029308
Title: Assessing Satisfaction with Emergency Department Translation Services among Spanish Speaking Patient Populations

Study Approval Period: 2/22/2017 to 2/22/2018

Dear S. Villalona:

On 2/22/2017, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
[Protocol Guidelines](#)

Consent/Assent Document(s)*:
[Phase 1B- Medical Staff Semi-Structured Interview Written Informed Consent V#1.pdf](#)
[Phases 2A, 2B, 2C- Modified Press Ganey Verbal Consent Spanish with HIPAA language V#1](#)
Granted a waiver

[Phases 2A, 2B, 2C- Modified Press Ganey Verbal Consent with HIPAA language V#1](#)
Granted a waiver

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved. Waivers are not stamped.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. (Verbal consent forms).

Your study qualifies for a waiver of the requirement for signed authorization as outlined in the HIPAA Privacy Rule regulations at 45CFR164.512(i) which states that an IRB may approve a waiver or alteration of the authorization requirement provided that the following criteria are met (1) the PHI use or disclosure involves no more than a minimal risk to the privacy of individuals; (2) the research could not practicably be conducted without the requested waiver or alteration; and (3) the research could not practicably be conducted without access to and use of the PHI. An alteration of HIPAA authorization is granted for this study. The study team will obtain verbal informed consent and HIPAA authorization from patient participants. This alteration therefore exempts the study team from the Privacy Rule's requirement that authorizations be signed and dated.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,



Kristen Salomon, Ph.D., Vice Chairperson
USF Institutional Review Board