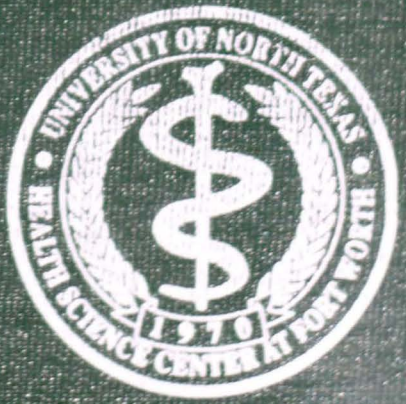
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There is a scarce number of Spanish-speaking, Hispanic physicians to serve a growing Spanish-speaking Hispanic population. A survey and interview were conducted in a primary health clinic with fifty-two Spanish-speaking Hispanic patients.

The Introduction (Chapter 1), included the problem and purpose; Literature Review (Chapter 2), analyzed supporting literature; Methodology (Chapter 3), described data process; Results (Chapter 4), reported the findings; and Conclusions and Recommendations (Chapter 5), included the discussion.

Spanish-speaking Hispanics in the study had more trust in Spanish-speaking Hispanic physicians than in non-Hispanic physicians who did not speak Spanish. More studies should include Spanish-speaking Hispanics and focus on differences in acculturation and the patient-physician relationship.

AN EXPLORATORY STUDY OF THE INFLUENCE OF LANGUAGE AND ETHNIC CONCORDANCE ON HISPANIC PATIENTS' TRUST IN THEIR HEALTHCARE PROVIDERS IN TARRANT COUNTY

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AN EXPLORATORY STUDY OF THE INFLUENCE OF LANGUAGE AND ETHNIC CONCORDANCE ON HISPANIC PATIENTS' TRUST IN THEIR HEALTHCARE PROVIDERS IN TARRANT COUNTY

THESIS

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CHAPTER I

INTRODUCTION

The number of people in the United States who speak a language other than English has grown significantly. The 2000 Census reveals that 44.9 million persons older than 5 years speak a language other than English at home, and this accounts for 18 % of the entire U.S. population (U.S. Census Bureau, 2000 as cited in Flores & Mendoza, 2002). Furthermore, the 2000 U.S. Census reports that Spanish is the language spoken by 26.7 million (60 %) of those who speak a language other than English at home (U.S Census Bureau, 2000 as cited in Flores & Mendoza, 2002). Current statistics, however, indicate that there is a scarce number of Spanish-speaking, Hispanic physicians who can more equitably serve the health needs of the growing Hispanic population. In the state of Texas, while Hispanics represented 32 percent of the population in 2000, only 7.8 percent of all physicians were of Hispanic origin (U.S. Census Bureau, 2000). Moreover, in the state of California, while 32.4 percent of the population was Hispanic, only 4 percent of physicians were Hispanic (Flores & Mendoza, 2002). Flores and Mendoza (2002) point out that although four percent does not represent all physicians who are fluent in Spanish, it estimates the number of physicians in California who are likely to be fluent and have a "strong sense" of the Hispanic culture.

Statement of the Purpose

The purpose of this study is to investigate the potential association between language and ethnic concordant patient-provider relationships and Hispanic patients' trust in their provider, satisfaction with care, compliance with treatment, and perceived health outcomes.

Research Questions

This study seeks to answer the following questions: (1) How does language concordance affect Hispanic patients' trust in their healthcare providers? (2) How does ethnic concordance affect Hispanic patients' trust in their healthcare providers? (3) How do Hispanic patients define trust and what are the components of trust in Hispanic patients' patient-provider relationship? (4) How does language concordance affect patient satisfaction, patient willingness to return for care, patient compliance with medical treatment and recommendations, and perceived health status? (5) How does ethnic concordance affect patient satisfaction, patient willingness to return for care, patient compliance with medical treatment and recommendations, and perceived health status?

Delimitations

The participants of this study consisted of self-reported Hispanic patients who were monolingual Spanish-speakers or who were of limited English proficiency and were able to read and write in Spanish. All participants were adults age 18 years and older. It

was required for all participants in both the survey and interview portion of the study to be able to read in Spanish in order to respond to the questions of the survey instrument of the study and be able to read and understand the patient consent letter. Participants recruited for the survey portion of the study were not allowed to participate in the interview portion of the study and vice-versa, in order to avoid predisposing the participants to the questions of either the interview or survey instrument. Every participant was treated by a physician at the clinic for no more than six months prior to the date of recruitment into the study.

Limitations

This study is subject to several limitations. This study was based upon self-reported responses that may not all be accurate, making this study subject to recall bias. Each question may be interpreted differently and potentially incorrectly by each participant and this may also add to the inaccuracy of the responses. An additional limitation which may compromise the validity of participants' responses is patients' potential lack of insight about being treated by language and ethnically concordant physicians, since most patients may not have experienced having a physician who is language and ethnically concordant. It was not determined in this study whether each participant had ever been seen by a Hispanic and a non-Hispanic physician, as well as a Spanish-speaking and a non-Spanish-speaking physician. Furthermore, the ethnicity of the current healthcare provider of each participant was not identified in this study.

Another potential limitation is that the sample size obtained for the study may not be large enough to be generalizeable.

Moreover, another limitation is that the Hispanic, Spanish-speaking segment of the population in Tarrant County who could not write or read were excluded from the study due to the fact that the data is based on a survey instrument which participants read and answered on their own in the survey portion of the study. It was also necessary for all study participants, including those in the interview portion, to be able to read and understand the participant consent letter. In addition, this study was also subject to selection bias, since participants were not randomly chosen, but were selectively chosen from a convenience sample by the co-investigator. This study may also have been subject to response bias, since only the co-investigator handed out the surveys to the participants and explained the purpose of the study. The fact that the co-investigator is Hispanic may have influenced the participants' responses. Moreover, the audio-recordings of the responses to the open-ended questions in the interview portion of the study may not have been heard clearly and may have been misinterpreted due to the background noise produced in the busy waiting areas of the clinic, since they were usually full to maximum capacity almost every day; this too may represent a limitation.

Assumptions

This study was based upon certain assumptions. One of the main assumptions was that the participants knew their appropriate ethnic classification. Furthermore, it was assumed that each participant had experienced having a Hispanic physician and a non-

Hispanic physician and/or a Spanish-speaking physician and a non-Spanish-speaking physician. It was also assumed the participant would be able to determine their preference for a Hispanic physician and/or a Spanish-speaking physician.

Moreover, it was assumed that the study participants understood the meaning of "trust" and were able to relate it to the physician-patient relationship.

Definition of Terms

The main focus of this study is the influence of physician-patient language concordance and ethnic concordance on patient trust. According to Cooper and Powe (2004), physician—patient language concordance refers to when a physician and patient share the same language and are able to communicate in that language. Similarly, physician-patient ethnic concordance refers to when a physician and patient share the same ethnicity. For instance, when a Hispanic physician treats a Hispanic patient there exists physician-patient ethnic concordance. Physician-patient language discordance and race or ethnic discordance refers to the opposite of concordance in that a physician and patient are not of the same race or ethnicity and do not share a common spoken language.

McGoldrick (1982) defines ethnicity as a sense of commonality transmitted over generations by the family and reinforced by the surrounding community; it involves conscious and unconscious processes that fulfill a deep psychological need for identity and historical continuity. Race, however, is defined by McGoldrick (1996) as an issue of political oppression, not a cultural or genetic matter; race is misused to define and divide the society by skin color and other physical features. This is the social and political

misuse of the biological concept of race. Race is an evolutionary dimension where human physical features have evolved over time and environmental conditions (McGoldrick, 1982).

Although the term "Hispanic" is not clearly defined by most sources, for the purposes of this study, the term Hispanic refers to persons born in Spanish speaking countries or descendants of such; the term generally does not include persons of French or Portuguese descent as the term Latino does (Sangillo, 2002).

Trust is a conceptual term which has been defined as "a firm belief or confidence in the honesty, integrity, reliability, and justice of another person or thing" (Hillman, 1998); "patients' confidence that the physician will do what is best for the patient" (Thom & Campbell, 1997); "the expectation that institutions and professionals will act in one's interests" (Baker, Mainous, Gray, & Love, 2003); and "the core, defining characteristic that gives the doctor-patient relationship meaning, importance, and substance" (Hall, Dugan, Zheng, & Mishra, 2001).

Although the concept of "trust" is difficult to define, in the context of healthcare, several studies indicate that trust is associated with patient satisfaction and continuity of care with provider, among other factors (Thom & Campbell, 1997; Doescher, Saver, Franks, & Fiscella, 2000; Baker et al., 2003). In this study the term "trust", as defined by Mainous, Kerse, Brock, Hughs, and Pruitt (2003), refers to "a relationship between the patient and doctor where the patient expects the doctor to provide advice and treatment in the best interest of the patient".

Importance of the Study

The disproportionate number of Spanish-speaking physicians to the number of Hispanics who speak limited English in the United States may pose a threat to the quality of health care being delivered to Hispanics in the United States and may have negative consequences for the health outcomes of this rapidly growing segment of the U.S. population. Furthermore, the unavailability of Hispanic physicians who may serve the Hispanic population in a culturally and linguistically appropriate manner represents a great inequality within the U.S healthcare system, since Hispanics are significantly less likely to have ethnic concordance with their regular physician, according to Saha, Komaromy, Koepsell, and Bindman (1999).

Additionally, various studies have indicated that trust in the physician-patient relationship affects important factors such as patient willingness to seek care; return to same physician; recommend physician; reveal sensitive information; and patient compliance with medical treatment (Hall et al., 2001; Baker et al., 2003). The information collected through this research has the potential benefit of revealing the most important qualities that primarily Spanish-speaking Hispanic patients seek in their health providers. Furthermore, the study may help reveal how Spanish-speaking Hispanic patients define trust and what qualities they perceive as trust-enhancing with in their physician-patient relationships.

Ultimately, this study may serve to further emphasize the importance and the need for having more Hispanic, Spanish-speaking physicians who may be more sensitive to Hispanic patients' healthcare needs.

CHAPTER II

LITERATURE REVIEW

The literature examined for this review includes studies that investigated issues of physician-patient communication and trust, the physician-patient relationship, patient satisfaction, language services in healthcare settings, racial/ethnic inequities in healthcare, and minority patient health outcomes.

As previously stated, the goal of this study is to answer the following questions:

(1) How does language concordance affect Hispanic patients' trust in their healthcare providers? (2) How does ethnic concordance affect Hispanic patients' trust in their healthcare providers? (3) How do Hispanic patients define trust and what are the components of trust in Hispanic patients' patient-provider relationship? (4) How does language concordance affect patient satisfaction, patient willingness to return for care, patient compliance with medical treatment and recommendations, and perceived health status? (5) How does ethnic concordance affect patient satisfaction, patient willingness to return for care, patient compliance with medical treatment and recommendations, and perceived health status?

Impact of Language & Ethnic Concordance and Language & Ethnic Discordance on Hispanic Patients' Satisfaction with their Physician-Patient Encounters

Language Concordant Physician-Patient Relationships

There is a considerable amount of evidence present in the literature that indicates that having a language concordant physician has a positive impact on Hispanic patients' satisfaction with their physician-patient encounters. Seijo, Gomez, and Freidenburg (1991) found that Spanish-speaking Hispanics with language concordant physicians asked more questions and had a greater recall of recommendations than Hispanic patients without language concordant physicians (Seijo et al., 1991 as cited in Cooper & Powe 2004). In another study, Lee, Batal, Maselli, and Kunter (2002) examined the effect of Spanish interpretation on Spanish-speaking patients' satisfaction with medical care. Lee and colleagues (2002) found that Spanish-speaking patients were most satisfied with their medical care in various aspects, such as listening, answers to questions, explanations, discussion of sensitive issues, support, skills, and mannerism, when they had a language concordant physician (Lee et al., 2002). Spanish-speaking patients were equally satisfied when they used AT&T professional interpretation services to communicate with their providers (Lee et al., 2002). Spanish-speaking patients were significantly less satisfied with using family and untrained bilingual staff or ad hoc interpreters to communicate with their physicians (Lee et al., 2002). Saha, Taggart, Komaromy, and Bindman (2000) revealed that Hispanics with Hispanic providers were more likely to speak primarily Spanish, which according to the study, reflects the importance of language in choosing a

provider. Another study conducted by Fernández, Schillinger, Grumbach, Rosenthal, Stewart, Wang, and Pérez-Stable (2004) revealed that Spanish-speaking patients at a public hospital outpatient department were more likely to report better interpersonal processes of care, such as communication and being caring and sensitive to patients' needs, when physicians have a higher self-rated ability to speak Spanish and higher self–rated cultural competence. The study also found that physicians fluent in Spanish were more likely than non-fluent physicians to elicit patients' problems and concerns, even when compared to non-fluent physicians who used professional interpreters to communicate with their Spanish-speaking patients (Fernández et al., 2004). This study supports the results of other studies which have shown that Spanish-speaking patients are less satisfied with their medical care when cared for by non-Spanish-speaking physicians.

In a study conducted by Mazor, Hampers, Chande, and Krug (2002), it was investigated whether a ten-week course in medical Spanish and cultural awareness that was given to pediatric emergency department (ED) physicians increased the patient satisfaction of families that only spoke Spanish (Mazor et al., 2002). After pediatric ED physicians participated in the 10-week course, Spanish-speaking families were found to be significantly more likely to strongly agree that the physician was concerned about their child, that the physician made them feel comfortable, was respectful, and listened to what the patient said (Mazor et al., 2002). The findings of the study also indicate that participating physicians improved their skills in obtaining information from Spanish-speaking patients (in mock interviews), increased their confidence in addressing selected ED chief complaints in Spanish, and were less likely to use an interpreter (Mazor et al.,

2002). An editorial by Flores and Mendoza (2002), however, points out that the post intervention levels of family satisfaction were still less than optimal since it is unlikely that physicians whose baseline Spanish was moderate to poor would achieve levels of conversational and medical Spanish equivalent to that of a medical interpreter after only twenty hours of study. Furthermore, the editorial mentions that the finding that physicians who participated in the 10-week course were less likely to use an interpreter may be due to false confidence in Spanish fluency (Flores & Mendoza 2002). The authors emphasized that, "Although the course served as a useful supplement to interpreters, it was not designed to replace them" (Flores & Mendoza, 2002).

Language Discordant Physician-Patient Relationships

In addition to the evidence present in the literature which shows that language concordant physicians have a positive impact on the satisfaction of Hispanic patients with their physician-patient encounters, the literature also reveals that language discordant physician-patient relationships can have a negative impact on Hispanic patients' satisfaction with their medical encounters. Morales, Cunningham, Brown, Liu, and Hays (1999) found Spanish-speaking Hispanics to be significantly more dissatisfied with provider communication than English-speaking Hispanic and White patients (Morales et al.,1999).

A study by Baker, Hayes, and Puebla-Fortier (1998) revealed that Spanish-speaking patients with language discordant physicians who communicated through an interpreter perceived their physician as less friendly, less respectful, and less concerned

for them as a person. In the same study, patients who did not have an interpreter when they thought one was necessary were even less satisfied than the group who communicated through an interpreter (Baker et al., 1998).

Another study by Rivadeneyra, Elderkin-Thompson, Silver, and Waitzkin (2000) found that patients with language discordant physicians who spoke through an interpreter made fewer comments during medical encounters than patients with language concordant physicians. The study also found that the non-Spanish-speaking physicians in the study were less likely to encourage Spanish-speaking patients to give commentaries about their symptoms compared to white patients, while English-speaking Latino patients were found to make more "offers" and received more "facilitation" by physicians for comments made (Rivadeneyra et al., 2000). The study defines a patient offer as any topic or question introduced by the patient during the medical encounter that was not a direct answer to a physician's question (Rivadeneyra et al., 2000). "Facilitation," which was not clearly defined in the article, seems to relate to how physicians encourage patients to express themselves, ask questions, and make more comments (Rivadeneyra et al., 2000).

One last study with findings showing evidence that language discordant physician-patient relationships have a negative impact on Hispanic patients' satisfaction with their medical encounters is by Carrasquillo, Orav, Brennan, and Burstin (1999). In this study it was revealed that Spanish-speaking patients were less satisfied with the care they received in the Emergency Department (ED) and were half as likely as English speakers to return to the same ED if they had another problem requiring emergency care (Carrasquillo et al., 1999). Furthermore, the study found that non-English speakers

reported more problems with care, including explanation of cause of medical condition, understanding discharge instructions, and explanation of reasons for diagnostic testing and their results (Carrasquillo et al., 1999).

The findings of the study by Carrasquillo and colleagues (1999) indicate that Hispanic patients' lack of satisfaction with medical care was linked to issues with language barriers, which could have been ameliorated in some way by having language concordant physicians.

Ethnic and/or Race Concordant Physician-Patient Relationships

As is the case with the positive impact that language concordant physicians have on Hispanic patients' satisfaction with their medical encounters, a review of the literature on ethnic and race concordant physician-patient relationships reveals that ethnic and race concordant physicians have a positive impact on Hispanic patients' satisfaction with care as well. Saha, Arbelaez, and Cooper (2003) found that Hispanics with ethnic concordant physicians reported greater satisfaction with healthcare overall.

Likewise, a study by Cooper-Patrick, Gallo, Gonzalez, Vu, Powe, Nelson, and Ford (1999) found that Hispanic patients with Hispanic physicians were more likely than those with non-Hispanic physicians to be very satisfied with healthcare overall (Cooper-Patrick et al., 1999 as cited in Cooper & Powe, 2004).

Garcia, Paterniti, Romano, and Kravitz (2003) found that patients prefer ethnic concordant physicians primarily because of concerns about language and empathic treatment, while another study by Saha et al. (2000) supports Garcia's findings in that the

study revealed that black and Hispanic patients sought care from physicians of their own race and/or ethnicity due to personal preference and language, not only due to geographic location (Cooper & Powe, 2004).

Similarly, Laveist and Nuru-Jeter (2002) found that patients with race concordant physicians reported greater satisfaction with physicians compared to patients with race discordant physicians. It was also found that patients who were able to choose their own physician were significantly more likely to choose a physician of their own race (Laveist & Nuru-Jeter, 2002).

A study by Gray and Stoddard (1997) found that minority patients were significantly more likely to report having a minority physician even when controlling for possible influential factors, and it concluded that minority physician-patient concordance was the result of physician and/or patient preferences. The findings by Gray and Stoddard (1997) conflict with those of the literature review by Cooper and Powe (2004) which revealed that minorities are less likely than white patients to have racial concordance with their regular physician. The disagreement between these two findings may be explained by the fact that the Gray and Stoddard study analyzed data from a survey conducted in 1987. The findings by Cooper and Powe (2004) are from a study by Saha et al. conducted in 1999, and race and ethnic discordance may have increased since 1987. Moreover, in a study by Cooper, Roter, Johnson, Ford, Steinwachs, and Powe (2003), race concordant encounters between African-American physicians and patients were found to last 10 % longer than race discordant encounters.

The study also revealed that race concordant encounters were characterized by higher patient ratings of satisfaction and higher ratings of patient positive affect (Cooper et al., 2003). Patient affect as described in this study by Cooper et al. (2003), has to do with the level of engagement, interest, friendliness, and responsiveness of the patient with the physician. Although this study focused on race concordant encounters between African-American physicians and patients, its findings serve to indicate that physician-patient race concordance positively affects a specific minority group's satisfaction with medical care.

Ethnic and/or Race Discordant Physician-Patient Relationships

Literature which demonstrates evidence that ethnic and/or race discordant physician-patient relationships can have a negative impact on Hispanic patients' satisfaction with their medical encounters is limited. Cooper and Powe (2004) examined a study by Oliver, Goodwin, Gotler, Gregory, and Stange (2001) which found that White physicians spend less time with African-American patients than with White patients on planning treatment, providing health education, chatting, assessing patients' health knowledge, and answering questions (Oliver et al., 2001 as cited in Cooper & Powe, 2004).

In a study conducted in the Netherlands, van Wieringen, Harmsen, and Bruijnzeels (2002) found that patient-provider ethnic discordance was associated with less talk and less positive physician affect, lower patient ratings of mutual understanding,

lower satisfaction with patient-physician communication and self-reported compliance, and higher rates of patient-reported problems with the physician.

Stevens, Shi, and Cooper (2003), conducted a study where parents reported on their children's primary care experiences and the responses from children in race concordant and discordant patient-provider relationships were compared (Stevens et al., 2003). In contrast to other findings discussed above, the study by Stevens and colleagues (2003) found that although minority patients generally reported poorer experiences than Whites in several aspects of primary care, patient-provider race nor ethnic concordance was associated with parent reports of primary care experiences in the sample of children investigated in the study (Stevens et al., 2003). Stevens et al. (2003) pointed out that this may be due to the fact that there were very few Spanish-speaking respondents (only 7 out of 1,200), and that the majority of the children and families in that sample who were English-speakers may not need to derive the same benefits from race concordance as non-English-speaking families (Stevens et al., 2003).

As demonstrated by a review of the literature, there is some literature which shows that race discordant physician-patient relationships may have a negative impact on patients' satisfaction with medical care and with their physician-patient encounters. However, there is little research in this area which focuses on Hispanics. As summarized by Ferguson and Candib (2002), Spanish-speaking patients with language discordant physicians are, "less likely to establish rapport with physicians and receive sufficient information, and are less likely to be encouraged to participate in medical-decision-making". Furthermore, minority patients are more likely to choose minority physicians,

be more satisfied by language concordant relationships, and are more likely to feel more involved in medical decision making with racially concordant physicians (Ferguson & Candib, 2002).

The relevance of examining studies focusing on other minority groups such as African Americans and race concordant and discordant physician-patient relationships is to emphasize that minority patients as a whole are significantly less likely to have race or ethnic concordance with their physician (Cooper & Powe, 2004), whether they are classified by ethnicity, as Hispanics are, or by race as African Americans are. Nevertheless, the classifications of race and ethnicity by no means share the same definition, as discussed in the Definition of Terms section in Chapter One.

Impact of Language Concordance & Discordance and Ethnic Concordance & Discordance on Hispanic Patients' Trust in Physician

A limited amount of research was found which focused on the impact of language concordance and discordance and ethnic concordance and discordance on Hispanic patients' trust in physicians.

One study which somewhat addresses the effect of language concordant physicians on Hispanic patients' trust is a study by Barkin, Balkrishnan, Manuel, and Hall (2003), which examined the effect of language immersion training for pediatric physicians on their communication with Latino patients. The study participants including five, non-Hispanic Caucasian, general pediatricians, underwent a two-week language immersion training in a Spanish language academy in Guatemala (Barkin et al., 2003).

The study found that the two-week language immersion program improved the three primary outcome measures, which were: changes in physicians' Spanish proficiency, parent's views of patient-doctor communication, and parents' trust in the physicians (Barkin et al., 2003). The authors point out, however, that the increase in trust was not dependent on how much language was acquired by the physicians (Barkin et al., 2003). It was concluded that it is possible that a different aspect of being immersed in another culture may have contributed to the increase in patient trust (Barkin et al., 2003).

In a study by Thom and Campbell (1997), four focus groups were conducted with a total of 29 participants. The study focused on investigating the components of trust in the physician-patient relationship and it was found that trust is highly correlated with patient satisfaction (Thom & Campbell, 1997). Thom and Campbell (1997) also found that important dimensions of trust include mutual understanding, caring, communication, and respect for patient autonomy. Moreover, it was revealed that better communication, mutual goals, and shared power were aspects perceived by patients as trust-enhancing (Thom & Campbell, 1997). Only one of the focus groups was composed of Hispanics; they were English-speaking, however (Thom & Campbell, 1997). Since no focus groups were conducted with Spanish-speaking Hispanics, the study did not actually address language concordance.

A study by Mainous, Baker, Love, Gray, and Gill (2001), examined primary care settings in the U.S. and the United Kingdom and explored the relationship between continuity of care and trust in one's physician. Similar to the findings of a study by Doescher et al. (2000), this study found that higher continuity of medical care with the

same physician is independently associated with a higher level of trust between a patient and physician, regardless of country of residence. Although this study did not focus on Hispanic patients in the U.S. and did not address language or ethnic concordance and discordance, it indicated that continuity of medical care with the same physician is an important factor of trust in the physician-patient relationship across two different countries.

A second study by Mainous et al. (2003), aimed to identify strategies used by doctors that increase patient trust and to compare and contrast potential similarities and differences in these strategies across two countries. The study revealed that physicians perceive that having a common language with their patients is crucial to developing the physician patient relationship and trust (Mainous et al., 2003). Furthermore, the study found that the physicians interviewed indicated that strategies like being unhurried and being willing to listen seemed to build trust, as well as knowledge of the patient's culture, and continuity of care of the same patient (Mainous et al., 2003).

Although many of the studies mentioned above do not directly address language and ethnic concordance and discordance issues in relation to patients' trust in their providers, the studies seem to underline key components of trust in the physician patient relation ship in general, if not specifically for Hispanic patients. Nevertheless, the need for research focusing on the components of trust in the doctor-patient relationship for Hispanics, especially Spanish-speaking Hispanics who are recent immigrants, is evident due to the gaps in the literature addressing this topic.

Impact of Language Concordance on Health Outcomes of Hispanic Patients

Examining the literature on how language concordance impacts the health outcomes of Hispanic patients is of importance as it describes a direct link between how language barriers affect the health status and outcomes of Hispanics disproportionately. There were limited studies focusing specifically on this issue.

Nonetheless, in one study, Pérez-Stable, Nápoles-Springer, and Miramontes (1997) conducted a cross-sectional study of general medicine patients with hypertension or diabetes to compare the effect of ethnicity and language concordance with their physician on health outcome measures, use of health care services, and clinical outcomes (Pérez-Stable et al., 1997). The study found that physician-patient language concordance was significantly associated with better functioning of self-reported health status including physical functioning, psychological well-being, health perceptions, and pain (Pérez-Stable et al., 1997). The study also revealed that language concordance was associated with better understanding and more asking of questions by Spanish monolingual patients than by those seen by language discordant physicians.

A study by Clark, Sleath, and Rubin (2004) examined the association of ethnicity and language concordance with physician-patient agreement (understanding) about the physicians' recommendations for change in behavior in various areas, including diet, exercise, medication, smoking, stress, and weight. The study found that whether the patients' primary language was spoken at the medical visit significantly affected physician-patient agreement. It was also found that language concordance positively influenced the likelihood of agreement about exercise (Clark et al., 2004). However,

according to the authors, ethnic concordance was not significantly associated with physician-patient agreement of recommended changes in behavior (Clark et al., 2004).

In one last study, Manson (1988) reviewed the charts of asthmatic monolingual Spanish-speaking patients to test the hypothesis that the ability of physicians to speak the same language as their asthmatic patients promotes patient compliance and use of office appointments versus ED visits (Manson, 1988). The study revealed that patients with language discordant physicians were more likely to omit medication, miss an appointment, and more likely to be noncompliant with medication (Manson, 1988). Furthermore, patients with language concordant physicians were found to be more likely to be compliant with taking medication than patients with language discordant physicians and they were more likely to keep their appointments with their primary care physician, even when controlling for insurance status, age, gender, and disease severity (Manson, 1988). The findings of this study by Manson (1988) seem to be the most concrete in establishing a connection in how language discordant physician-patient relationships negatively impact the health outcomes of Hispanic patients, while language concordant relationships have a positive impact on the health outcomes of Hispanic patients.

Examining the literature on how language barriers may lead to adverse health outcomes in Hispanic patients is relevant to this study; since this study is examining perceived health status which is based solely on patient perception, it is of importance to present studies which demonstrate the actual effects that language concordance, in particular, has on health outcomes of Hispanics.

Conclusions

A review of the literature on how language and ethnic concordance and discordance impact Hispanic patients' satisfaction with their patient-provider encounters indicates that, overall, Hispanic patients are more satisfied with their physician-patient encounters, have more trust in their providers, have improved health outcomes, understand more and make more comments during medical encounters, and are more involved in their medical decision-making, when they have a language concordant and ethnic concordant providers (Pérez-Stable et al., 1997; Manson, 1998; Laveist & Nuru-Jeter, 2002; Lee et al., 2002; Mazor et al., 2002; Garcia et al., 2003; Saha et al., 2003; Cooper & Powe, 2004; Fernández et al., 2004). Conversely, Hispanic patients' with language discordant and ethnic discordant providers tend to be less satisfied with medical care, make less comments and ask fewer questions during their medical encounters, and are less likely to return for medical care (Baker et al.,1998; Carrasquillo et al., 1999; Morales et al., 1999; Rivedeneyra et al., 2000).

Although there is limited research addressing issues of how physician-patient language concordance and discordance impact Hispanic patients' satisfaction with their medical encounters, there is a scarcity of research which addresses the issue of how physician-patient language concordance affects Hispanic patients' trust in physicians. More research is needed which focuses on exploring the factors which lead to trust of Spanish-speaking Hispanic patients in physicians. Questions for further research related to this topic may be: "How important is language concordance in comparison to ethnic

concordance in determining Hispanic patients' trust in physicians?" and "What factors are most important in determining Hispanic patients' trust in physicians?"

A review of the literature indicates that there exist few studies which specifically elucidate whether ethnic discordance negatively affects Hispanic patients' satisfaction when there is language concordance. The study by Clark et al. (2004) addresses this issue somewhat indirectly, as it found that ethnicity concordance was not significantly associated with physician-patient agreement or understanding of recommended changes in health behavior, while language concordance was significantly associated with physician-patient agreement of recommended changes in certain health behaviors. A more specific question for further research may be: "Does physician-patient ethnic discordance negatively impact Hispanic patients' satisfaction with their patient-provider encounters when there is language concordance?"

Also, more research should center on how physician-patient language concordance impacts health outcomes for Hispanic patients. More studies revealing the positive impact of patient-provider language concordance on health outcomes among Hispanic patients will provide concrete evidence of the need for more Hispanic Spanish-speaking physicians. This may encourage an increase in physician diversity in the U.S. healthcare system.

Chapter Two presented a review of the literature based on the research questions of the study and related topics. The review of the literature was accomplished by a thorough search on databases including Academic Search Premier and Medline (Ovid).

The literature review presented literature which examined issues related to Hispanic patients and the physician-patient relationship; patient satisfaction; trust in physicians; racial/ethnic inequities in healthcare; and health outcomes of Hispanic patients.

CHAPTER III

METHODOLOGY

The following chapter will describe the research design of this study and the methodology used to conduct the research. The research design of this study was a mixed methods approach consisting mostly of qualitative research methods. The study consisted of a survey portion utilizing a multiple choice survey instrument, while the interview portion involved a face-to-face interview composed of six open-ended questions.

Population and Sample

The participants of this study consisted of 52 Hispanic patients who were monolingual Spanish-speakers or who spoke limited English. Forty-six subjects participated in the survey portion of the study while 6 subjects participated in the interview portion of the study. Participants included both males and females and all were adults ranging in age between 20 and 75 years old. All participants self-reported the information and were able to read and write in Spanish. The participants were all patients from JPS Health Center Diamond Hill and were seen by a physician at the clinic no more than six months prior to the date the survey was completed.

Protection of Human Participants

The protocol submitted to the Institutional Review Board (IRB) for the Protection of Human Subjects of the University of North Texas Health Science Center (UNTHSC) Fort Worth was approved on February 28, 2006, while the IRB protocol submitted to the IRB committee of the primary care clinic where data collection took place was approved on April 4, 2006. Before data collection began, all key personnel involved in the study completed the UNTHSC Health Insurance Portability and Accountability Act (HIPAA) online training. The IRB protocol submitted to the IRB of UNTHSC included the HIPAA training certificates of all of the key personnel.

Before participants filled out the survey, it was explained to each subject that participation in the survey is completely voluntary and that they may withdraw from the study at any time without penalty, as explained in the consent letter, which was given to all participants to keep. All measures were taken to protect the confidentiality of study participants (subjects). No subjects were identifiable with the exception of the voice recordings in the interview portion. Subjects were otherwise not identified. After the transcription of the recorded interviews, all recordings were destroyed. The security of the surveys while conducting the study was under the care of the co-investigator until the completion of data collection. The data will be retained by the investigator for a minimum of five years in a locked file cabinet at the University of North Texas Health Science Center (EAD-730).

Data Collection Procedures

All subjects were recruited from the waiting areas of a primary care clinic located in a predominantly Hispanic area of Fort Worth, Texas. Data collection took place from April of 2006 through May of 2006. Before beginning the survey, all participants were given a letter in Spanish which explained the purpose of the study. The co-investigator reviewed the letter with all participants. Inclusion criteria were confirmed with the patients before they were officially recruited for the study. All participants were asked if they spoke Spanish and if they considered themselves to be Hispanic; if they had been seen by a physician at the clinic within the last six months; if they could read and write in Spanish; and all participants were asked if they were over the age of 18 years old. Mothers who were never seen by a physician at the clinic but had regular appointments with their children's pediatricians at the clinic were allowed to participate as long as their visit was within the past six months.

The survey was completed by willing participants, in the main waiting area of the clinic. The co-investigator was available to answer questions about any of the items in the survey or interview. Patients were mainly approached during the time before they were called in to be seen by their physician, and the patient's visit with the healthcare provider was not interrupted or impeded in any way. Participants that had begun the survey but were called in to be seen by the physician before completing the survey were not asked to stay and finish the survey; incomplete surveys were still collected. Incomplete surveys were completed by some participants willing to return to the waiting area to complete the survey after being seen by their physician. The audio-recorded

interviews were held in a more private area away from the main waiting area in order to ensure privacy. Interviews were not held in a completely enclosed room in order to avoid patients missing their names being called for their physician clinic appointment. One interview was held outside of the waiting area with a patient that had already been seen by their physician and was willing to participate.

Instrumentation

Survey Portion

The survey instrument developed for the study was multiple-choice and consisted of a Likert scale with answer options ranging from Strongly Agree, Agree, Disagree, to Strongly Disagree. It contained 32 items and was designed to be completed in approximately 10 to 15 minutes. Most surveys were completed by participants in less than 10 minutes. Data elements collected from the survey instrument included the following:

a. Demographic characteristics of the patients
b. Clinic visits
c. Preferred language
d. Educational attainment
e. Patient trust in physician
f. Importance of language and race concordance with provider
g. Compliance with medical instructions and recommendations
h. Perceived quality of care

i. Willingness to return or recommend clinic to someone

j. Perceived health status

Table 1. Survey Data Elements and Sample Survey Questions

DATA ELEMENT	SAMPLE QUESTIONS
Demographic characteristics of the patients	Number of years in the U.S.
Clinic visits	How often do you seek medical care at this clinic?
Preferred language	What language do you speak most at home?
Educational attainment	How many years of schooling did you complete and where did your schooling take place?
Patient trust in physician	I have more trust in a Hispanic physician who speaks Spanish than in Hispanic physician who does not speak Spanish.
Importance of language and race concordance with provider	It is equally important for my doctor to be Hispanic and speak Spanish.
Compliance with medical instructions and recommendations	I would follow my doctor's instructions more carefully if my doctor spoke Spanish.
Perceived quality of care	Spanish-speaking physicians of this clinic treat me with more dignity and respect than non-Spanish-speaking physicians
Willingness to return or recommend clinic to someone	I would return to this clinic due to my satisfaction with the medical care given by the Hispanic doctors of this clinic.
Perceived health status	I would be in better health if I had a regular primary care physician that was Spanish-speaking.

Interview Portion

Six participants were recruited for the interview portion of the study which consisted of six open-ended questions.

Data elements collected from the interview included the following:

a. Demographic characteristics of the patients

b. Educational attainment

c. Preferred language

d. Clinic visits

e. Qualities patient seeks in physician

f. Patient trust in physician

g. Definition of trust

Table 2. Interview Data Elements and Sample Interview Questions

DATA ELEMENT	SAMPLE QUESTIONS
Qualities patient seeks in physician	What qualities do you seek in a physician? Which do you consider a more important quality in a physician: Spanish-speaking ability or being Hispanic?
Patient trust in physician	How important is it for you to be able to trust your physician?
Definition of trust	What do you mean when you say the word 'trust'?

The patient's responses to these questions were audio-recorded with the patient's permission while the investigator took notes on the participant's response to each question. Interviews were labeled "Interview one" to "Interview six". All recorded interviews were heard and transcribed adequately except for Interview 5 which did not record completely for unknown reasons. Notes taken by the co-investigator during the interviews were included at the end of each transcription.

Data Analysis

SPSS 15.0 statistical software was used to analyze the survey data from the survey portion and the demographics of the interview portion of the study. Descriptive statistics were reported for the data collected from the responses to the survey instrument

items. Chi square tests were also performed for selected variables in the survey portion; associations between the selected variables were analyzed. Fisher's Exact Test was used whenever there was less than five expected cell count per cell. The responses to the interview portion of the study were transcribed and major trends were reported.

Summary

Chapter Three, the methodology section, described the population and sample of the study; it has also defined how the protection of human participants was ensured. Chapter Three also fully explained the data collection procedures which took place; it presented the instruments used to collect data and finally, it also defined the type data analysis used for the results of the study. Data collection procedures involved a multiple choice survey instrument utilizing a Likert scale and an interview instrument of six questions.

CHAPTER IV

RESULTS

A total of 52 patients participated in the study. Forty-six patients participated in the survey portion of the study while six patients participated in the interview portion of the study.

Survey Portion

Demographics

Thirty-eight of the 46 surveys obtained were fully completed by the participants while a total of eight surveys were not completed. Of the total number of participants, four (8.7%) were male and 42 (91.3%) were female. All participants were adults ranging in age between 20 and 75 years old. The mean age of the total number of participants was 35.4 years old. The age of the majority of participants fell in between the range of 27 and 35 years of age. The largest percentage of the sample was age 30 (11.1%). The native country of the majority of participants was México (93.5%) although the sample also contained participants from the countries of El Salvador (4.3%) and Venezuela (2.2%). The number of years living in the United States varied with in the sample. The average number of years living in the United States was 11.5 years and ranged from less than one year to 36 years. The majority of the sample (15.2%) had been living in the United States for at least 10 years. The majority of participants spoke Spanish only

(97.8%) while only one patient preferred to speak both English and Spanish at home, with the primary language as Spanish. Approximately thirty percent (30.4%) of the participants in the survey portion of the study had completed at least nine years of schooling in their native country, mainly México; and only 2 of the 46 participants had completed at least nine years of education in the United States.

Table 3. Summary of Demographics of Participants in Survey Portion of Study (N=46)

DEMOGRAPHICS	MEAN	MODE	PERCENTAGE
AGE	35.4	30	
27 to 35 years			52%
GENDER			
Male			8.7%
Female			91.3%
COUNTRY OF ORIGIN			
México			93.5
El Salvador			4.3
Venezuela			2.2
NUMBER OF YEARS IN THE U.S	11.5	10	
10 to 20 years			36.9%
LANGUAGE PREFERENCE			
Spanish			97.8
English & Spanish			2.2
EDUCATIONAL ATTAINMENT	7.3	9	
3 years			10.9
6 years			15.2
9 years			30.4
12 years			4.3

Patient Trust in Physician

Over ninety percent of participants in the survey portion of the study answered either "Strongly Agree" (72.7%) or "Agree" (18.2%) for the statement "I have more trust in a Hispanic doctor who speaks Spanish than in a Hispanic doctor who does not speak Spanish." For the statement "I have as much trust in a non-Hispanic physician that speaks Spanish as in a Hispanic physician that does not speak Spanish", the majority of

participants answered "Strongly Agree" (51.2%) or "Agree" (30.2%) while sixteen percent (16.3%) answered "Strongly Disagree".

Importance of Language Concordance and Ethnic Concordance with Provider

Seventeen percent (17.1%) of participants answered "Strongly Disagree" to the statement "It is not important that my doctor be Hispanic", while a total of almost eighty percent answered "Strongly Agree" (43.9%) or "Agree" (34.1%). Approximately eighty-eight percent of participants answered "Strongly Agree" (64.3%) or "Agree" (23.8%) to the statement "It is equally important for my doctor to be Hispanic and speak Spanish".

Compliance with Medical Instructions and Recommendations

Approximately ninety percent of participants answered "Strongly Agree" (83.3%) or "Agree" (7.1%) to the statement "I would follow my doctor's instructions more carefully if my doctor spoke Spanish". For the statement "I would follow my doctor's instructions more carefully if my doctor were Hispanic," almost eighty percent of participants answered "Strongly Agree" (54.8%) or "Agree" (23.8%), while fourteen percent (14.3%) answered "Strongly Disagree". Almost seventy percent of participants responded "Strongly agree" (54.8%) or "Agree" (14.3%) for the statement "I would keep my appointments more often if my physician spoke Spanish", while over twenty-five percent (26.2%) answered "Strongly Disagree". For the statement "I would keep my appointments more often if my physician were Hispanic", approximately seventy-four

percent responded "Strongly Agree" (54.8%) or "Agree" (19%) while almost seventeen percent (16.7%) responded "Strongly Disagree".

Perceived Quality of Care

Half of participants answered "Strongly Disagree" (50%) for the statement "I am less satisfied with my medical appointments when my doctor is Hispanic", while over forty percent answered "Strongly Agree" (27.3%) or "Agree" (15.9%). Over ninety percent of participants answered "Strongly Agree" (86%) or "Agree" (7.0%) for the statement "I am more satisfied with my medical appointments when my doctor speaks Spanish". For the statement "The Spanish-speaking physicians of this clinic treat me with more dignity and respect than non-Hispanic, non-Spanish-speaking physicians," over forty percent of participants answered "Strongly Disagree," (41.5%) while over fifty percent of participants answered "Strongly Agree" (29.3%) or "Agree" (22%). Over fifty percent of participants answered "Strongly Agree" (23.8%) or "Agree" (28.6%) for the statement "The Hispanic physicians of this clinic treat me with more dignity and respect than non-Hispanic, non-Spanish-speaking physicians," while almost thirty-six percent (35.7%) answered "Strongly Disagree".

Willingness to Return or Recommend Clinic

Over ninety-five percent of participants answered "Strongly Agree" (81%) or "Agree" (14.3%) for the statement "I would return to this clinic due to my satisfaction with the medical care given by the Spanish-speaking doctors of this clinic". Similarly,

over ninety percent answered "Strongly Agree" (78.6%) or "Agree" (14.3%) for the statement "I would return to this clinic due to my satisfaction with the medical care given by the Hispanic doctors of this clinic". For the statement "I would recommend this clinic to someone due to my satisfaction with the medical care given by the Spanish-speaking doctors of this clinic" approximately ninety-two percent answered "Strongly Agree" (84.6%) or "Agree" (7.7%), while for the statement "I would recommend this clinic to someone due to my satisfaction with the medical care given by the Hispanic doctors of this clinic", almost ninety-eight percent of participants answered "Strongly Agree" (87.2%) or "Agree" (10.3%).

Perceived Health Status

Approximately sixty-four percent of participants answered "Strongly Agree" (35.9%) or "Agree" (28.2%) for the statement "I would be in better health if I had a doctor that was Spanish-speaking", while over twenty-five percent answered "Strongly Disagree" (25.6%). For the statement "My health would be worse if I had a Hispanic primary care provider," only approximately twenty-three percent answered "Strongly Agree" (12.5%) or "Agree" (10.0%) while over seventy percent answered "Strongly disagree" (72.5%).

Table 4. Summary of Descriptive Statistics of Responses to Survey Instrument

Category/Question	% Strongly Agree	% Agree	% Strongly Disagree
Patient Trust in Physician			
"I have more trust in a Hispanic doctor who speaks Spanish than in a Hispanic doctor who does not speak Spanish."	72.7	18.2	4.5
"I have as much trust in a non-Hispanic physician that speaks Spanish as in a Hispanic physician that does not speak Spanish"	51.2	30.2	16.3
Importance of Language Concordance and Ethnic Concordance with Provider			
"It is not important that my doctor be Hispanic"	43.9	34.1	17.1
"It is equally important for my doctor to be Hispanic and speak Spanish"	64.3	23.8	7.1
Compliance with Medical Instructions and Recommendations			
"I would follow my doctor's instructions more carefully if my doctor spoke Spanish"	83.3	7.1	4.8
"I would follow my doctor's instructions more carefully if my doctor were Hispanic"	54.8	23.8	14.3
"I would keep my appointments more often if my physician spoke Spanish"	54.8	14.3	26.2
"I would keep my appointments more often if my physician were Hispanic"	54.8	19.0	16.7
Perceived Quality of Care			
"I am less satisfied with my medical appointments when my doctor is Hispanic"	27.3	15.9	50.0
"I am more satisfied with my medical appointments when my doctor speaks Spanish"	86.0	7.0	4.7
"The Spanish-speaking physicians of this clinic treat me with more dignity and respect than non-Hispanic, non-Spanish-speaking physicians"	29.3	22.0	41.5
"The Hispanic physicians of this clinic treat me with more dignity and respect than non-Hispanic, non-Spanish-speaking physicians"	23.8	28.6	35.7
Willingness to Return or Recommend Clinic			
"I would return to this clinic due to my satisfaction with the medical care given by the Spanish-speaking doctors of this clinic"	81.0	14.3	2.4
"I would return to this clinic due to my satisfaction with the medical care given by the Hispanic doctors of this clinic"	78.6	14.3	7.1
"I would recommend this clinic to someone due to my satisfaction with the medical care given by the Spanish-speaking doctors of this clinic"	84.6	7.7	2.6
"I would recommend this clinic to someone due to my satisfaction with the medical care given by the Hispanic doctors of this clinic"	87.2	10.3	0
Perceived Health Status			
"I would be in better health if I had a doctor that was Spanish-speaking"	35.9	28.2	25.6
"My health would be worse if I had a Hispanic doctor"	12.5	10.0	72.5

Crosstabulations

Variables of interest were examined in order to determine potential associations between the variables. Table 5 presents the results from the crosstabulation between the variables "I have more trust in a Hispanic physician who speaks Spanish than in a Hispanic physician who does not speak Spanish" and "I have as much trust in a non-Hispanic-physician who speaks Spanish as in a Hispanic physician that speaks Spanish". Association between the variables was statistically significant ($p<0.01$) (Table 5).

Of the four participants who responded that they disagree to having more trust in a Hispanic physician who speaks Spanish than in a Hispanic physician who does not speak Spanish, 100% also disagree with having as much trust in a non-Hispanic physician who speaks Spanish as in a Hispanic physician that speaks Spanish.

Table 6 presents the crosstabulation between the variables "It is equally important for my doctor to be Hispanic and speak Spanish" and "I would keep my appointments more often if my physician spoke Spanish". The association between the two variables was also statistically significant ($p<0.01$) (Table 6).

Almost eighty percent (79.4%) of the 34 participants who responded they agree it is equally important for their physician to be Hispanic and speak Spanish, also responded they agree that they would keep their appointments more often if their physician spoke Spanish. Out of the 39 participants who responded to both statements examined in Table 6, just under 70% (69.2%) responded they agree it is equally important for their physician to be Hispanic and they agree they would keep their appointments more often if their physician spoke Spanish.

Table 5. Crosstabulation between variables "I have more trust in a Hispanic physician who speaks Spanish than in a Hispanic physician who does not speak Spanish" and "I have as much trust in a non-Hispanic-physician who speaks Spanish as in a Hispanic physician that speaks Spanish".

			I have as much trust in a non-Hisp. phys. who speaks Span, as in Hisp. phys. that spks Span.		Total
			Disagree	Agree	
I have more trust in a Hispanic phys. who speaks Span. than in a Hisp. phys. who does not spk. Span.	Disagree	Count	4	0	4
		Expected Count	.7	3.3	4.0
		% within I have more trust in a Hispanic phys. who speaks Span. than in a Hisp. phys. who does not spk. Span.	100.0%	.0%	100.0%
		% within I have as much trust in a non-Hisp. phys. who speaks Span, as in Hisp. phys. that spks Span.	50.0%	.0%	9.3%
		% of Total	9.3%	.0%	9.3%
	Agree	Count	4	35	39
		Expected Count	7.3	31.7	39.0
		% within I have more trust in a Hispanic phys. who speaks Span. than in a Hisp. phys. who does not spk. Span.	10.3%	89.7%	100.0%
		% within I have as much trust in a non-Hisp. phys. who speaks Span, as in Hisp. phys. that spks Span.	50.0%	100.0%	90.7%
		% of Total	9.3%	81.4%	90.7%
Total		Count	8	35	43
		Expected Count	8.0	35.0	43.0
		% within I have more trust in a Hispanic phys. who speaks Span. than in a Hisp. phys. who does not spk. Span.	18.6%	81.4%	100.0%
		% within I have as much trust in a non-Hisp. phys. who speaks Span, as in Hisp. phys. that spks Span.	100.0%	100.0%	100.0%
		% of Total	18.6%	81.4%	100.0%

Fisher's Exact Test p-value < 0.01

Table 7 presents the results for the crosstabulation between the variables,"I have more trust in a Hispanic physician who speaks Spanish than in a Hispanic physician who does not speak Spanish" and "I am more satisfied with my medical appointments when my Dr. speaks Spanish", which also resulted in a significant association between the two variables (p-value < 0.05). Out of the four participants who disagree to have more trust in a Hispanic physician who speaks Spanish than in a Hispanic physician who does not speak Spanish, 50% also disagree with being more satisfied with their medical appointments when their physician speaks Spanish. Out of the three who disagree they are more satisfied with their medical appointments when their physician speaks Spanish, 66.7% disagree with having more trust in a Hispanic physician who speaks Spanish than in a Hispanic physician who does not speak Spanish.

Table 6. Crosstabulation between variables "It is equally important for my doctor to be Hispanic and speak Spanish" and "I would keep my appointments more often if my physician spoke Spanish".

			I would keep my appointments more often if my phys. spoke Spanish		
			Disagree	Agree	Total
It is equally important for my doctor to be Hispanic and speak Spanish	Disagree	Count	5	0	5
		Expected Count	1.5	3.5	5.0
		% within It is equally important for my doctor to be Hispanic and speak Spanish	100.0%	.0%	100.0%
		% within I would keep my appointments more often if my phys. spoke Spanish	41.7%	.0%	12.8%
		% of Total	12.8%	.0%	12.8%
	Agree	Count	7	27	34
		Expected Count	10.5	23.5	34.0
		% within It is equally important for my doctor to be Hispanic and speak Spanish	20.6%	79.4%	100.0%
		% within I would keep my appointments more often if my phys. spoke Spanish	58.3%	100.0%	87.2%
		% of Total	17.9%	69.2%	87.2%
Total		Count	12	27	39
		Expected Count	12.0	27.0	39.0
		% within It is equally important for my doctor to be Hispanic and speak Spanish	30.8%	69.2%	100.0%
		% within I would keep my appointments more often if my phys. spoke Spanish	100.0%	100.0%	100.0%
		% of Total	30.8%	69.2%	100.0%

Fisher's Exact Test p-value < 0.01

Table 7. Crosstabulation between variables "I have more trust in a Hispanic physician who speaks Spanish than in a Hispanic physician who does not speak Spanish" and "I am more satisfied with my medical appointments when my Dr. speaks Spanish".

			I am more satisfied with my medical appts. when my Dr. speaks Spanish		
			Disagree	Agree	Total
I have more trust in a Hispanic phys. who speaks Span. than in a Hisp. phys. who does not spk. Span.	Disagree	Count	2	2	4
		% within I have more trust in a Hispanic phys. who speaks Span. than in a Hisp. phys. who does not spk. Span.	50.0%	50.0%	100.0%
		% within I am more satisfied with my medical appts. when my Dr. speaks Spanish	66.7%	5.1%	9.5%
		% of Total	4.8%	4.8%	9.5%
	Agree	Count	1	37	38
		% within I have more trust in a Hispanic phys. who speaks Span. than in a Hisp. phys. who does not spk. Span.	2.6%	97.4%	100.0%
		% within I am more satisfied with my medical appts. when my Dr. speaks Spanish	33.3%	94.9%	90.5%
		% of Total	2.4%	88.1%	90.5%
Total		Count	3	39	42
		% within I have more trust in a Hispanic phys. who speaks Span. than in a Hisp. phys. who does not spk. Span.	7.1%	92.9%	100.0%
		% within I am more satisfied with my medical appts. when my Dr. speaks Spanish	100.0%	100.0%	100.0%
		% of Total	7.1%	92.9%	100.0%

Fisher's Exact Test p-value < 0.05

Interview Portion

Demographics

Six patients agreed to be interviewed for the interview portion of the study. Only five of the six interviews were audio-recorded successfully; the fifth interview was inaudible for unknown reasons. The demographics of the participants in the interview portion of the study differed slightly from the demographics of the participants in the survey portion of the study, mainly in age and educational attainment. Table 8 compares selected demographic statistics of survey participants versus interview participants. The mean age of the survey participants was 35.4 years while that of the interview participants was 53.8 years. The mean number of years of educational attainment of the survey participants was 7.3 years while that of the interview participants was only 3.5 years. The participants ranged in age from 35 to 68 years old; the mean age was 53.8. Only one of six participants was male (16.7%) while five were female (83.3%). All of the participants were born in México and they had all been living in the United States from one and a half years to forty-two years. The mean number of years living in the United States was 12.75 years. All participants preferred to speak Spanish predominantly. Education took place in México for all participants and years of educational attainment ranged from two years to six years. The mean number of years of education among the participants was three and a half years; fifty percent of interview participants had completed a total of only two years of education.

Table 8. Comparison of Selected Demographics for Participants in Survey Portion (N=46) vs. Interview Portion of Study (N=6)

DEMOGRAPHICS	SURVEY	INTERVIEW
AGE RANGE (YEARS)	27 to 35	35 to 68
MEAN AGE	35.4	53.8
GENDER		
MALE	8.7%	16.7%
FEMALE	91.3%	83.3%
NUMBER OF YEARS IN THE U.S.	10 to 20	1.5 to 42
EDUCATIONAL ATTAINMENT (MEAN NUMBER OF YEARS)	7.3	3.5

Interview Responses

Participants' interview responses can be divided into the categories "Qualities Patient Seeks in Physician", "Patient Trust in Physician", and "Definition of Trust".

Qualities Patient Seeks in Physician

Two of the most prevalent responses in terms of qualities sought in a physician among interview participants were that the physician speak Spanish and be *amable* or polite/kind. Five of six interview participants responded that the qualities they seek in a physician is that their physician speak their same language. Five of six participants also responded that they wanted their physician to be *amable* or they stated that they wanted to be treated well or treated attentively, which relates back to being treated with *amabilidad* or kindness.

TRANSCRIPTION KEY	
....	Indicates a pause
XXX	Indicates inaudible sound (Each "X" is a syllable)

In response to the question "What qualities do you seek in a physician?", one patient (Interview 3) stated:

> Que hable español...si para podernos entender bien el idioma.
>
> That he (Dr.) speak Spanish...yes, so that we can understand the language well.

Another patient interviewed (Interview 4) responded:

> Pues que hable español para que me pueda explicar todos los problemas que hay...este...que sea amable con uno, ¿no?
>
> Well that he (Dr.) speak Spanish so that he can explain everything that is wrong...and...that he be polite with us, right?

In response to the same question the last patient interviewed (Interview 6) stated:

> Pues, uh, que me atiendan mejor, que tenga paciencia para entender a uno y pues que hablen español.
>
> Well, uh, that they treat me better, that he have patience in order to understand us and, well, that they speak Spanish.

Being treated with respect also seemed to be an important quality in a physician to one patient (Interview 2) who stated:

Pues que traten a uno con atención...con respeto...con amabilidad...y se siente uno más...en confianza, más cómodo, porque...si lo tratan a uno así con...desprecio, pues uno se siente muy incomodo si XXX.

Well that they (doctors) treat us attentively...with respect...with kindness...and one feels more trusting, more comfortable, because if they (doctors) treat us like that...with despise, well we feel too uncomfortable if XXX.

One other patient (Interview 1) mentioned that it was important for him that his physician answer all of his questions in addition to speaking his same language, as he stated:

Que se...que hable el mismo idioma que yo...Pues que lo atienda a uno bien y que...conteste las preguntas que, que uno le hace a ellos...

That he (doctor)...that he speak the same language as I...well that he treat us well and...that he answer all of the questions we ask them...

When asked, "Which do you consider a more important quality in a physician Spanish-speaking ability or being Hispanic? Why?", the participants were divided. Four of six participants responded that it was most important for their doctor to be Hispanic. One participant stated that both qualities were equally important while one other participant stated that neither being Hispanic nor Spanish-speaking were as important as the "qualities" of a doctor. As one participant (Interview 2) stated:

No es tan importante que sea hispano...este...lo importante es este...son las cualidades del doctor...Porque aunque no sea hispano pero hay forma de...de que lo traduzcan a uno...

It's not very important that he (doctor) be Hispanic...what is important are the qualities of the doctor...because even if he is not Hispanic there is a way...for someone to interpret for us...

In response to the same question, another participant (Interview 4) stated:

32—I4: Ser hispano.

(For the doctor) to be Hispanic.

33—Isela: ¿Ser hispano? ¿Si? ¿Es más importante?

(For the doctor) to be Hispanic? Yes? It's more important?

34—I4: Si...

Yes

35—Isela: Entonces ¿porqué es más importante que sea hispano versus que hable español? ¿Qué diría usted?

So why is it more important (that the doctor) be Hispanic versus that he (be able to) speak Spanish? What would you say?

38—I4: No se.

I don't know.

39—Isela: ¿No sabe? ¿Será que tiene que...usted cree que tiene que ver con la confianza?

Oh...

You don't know? Could it be that it...do you think it has to do with trust? Or...

40—I4: Pues si…

Well, yes…

41—Isela: Tiene que ver con la confianza?

It has to do with trust?

42—Isela: ¿Confiaría más usted en un doctor hispano entonces?

Would you have more trust in a Hispanic doctor then?

43—I4: Uh-huh

Uh-huh

44—Isela: ¿Sí?

Yes?

45—I4: Si.

Yes.

One participant (Interview 6) mentioned that she felt that if she had a Hispanic physician the physician would treat her better or take better care of her, as she stated:

33—Isela: Usted cree que si tuviera un doctor hispano, eh…la atendiera mejor entonces?

You think that if you had a Hispanic doctor, uh…he would take better care of you then?

34—I6: Pues…pues…a cualquiera, uh-huh, a cualquiera porque entienden…creo que entienden mejor.

> Well...well...anybody, uh-huh, (the doctor would take better care of) anybody because they understand better...I think they understand better.

In summary, the main qualities mentioned by interview participants as most important in a physician were that the physician speak Spanish, that the physician treat them kindly and with respect, and that the physician be attentive. The majority of the participants also mentioned that it was important for them that their physician be Hispanic.

Patient Trust in Physician

All interview participants responded that it was it was very important for them to be able to trust their doctor. When asked, "How important is it for you to be able to trust your physician?", one participant (Interview 4) responded:

> Pues...es lo principal ¿no? poder confiar en ellos...es lo mas importante.
>
> Well...it's what's most important isn't it? To be able to trust in them...it's what's most important.

The second participant interviewed (Interview 2) responded similarly stating:

> Pues yo creo que para toda persona es sumamente importante, importante tener confianza con una persona que...o sea, que lo atiende a uno.
>
> Well, I think that it is extremely important for every person; it is important to trust someone that is taking care of you.

Another participant (Interview 6) responded that she felt better taken care of by her doctor when she felt she could trust her doctor stating:

3—Isela: …Okay ¿que importante es para usted poder confiar en su doctor?

Okay, how important is it for you to be able to trust your doctor?

4—I6: Muchísimo.

Very (important).

5—Isela: ¿Mucho? ¿Por qué razón?

Very (important)? For what reason?

6—I6: Porque así este…uno se siente mejor atendido

Because that way…one feels better taken care of.

7—Isela: ¿Cuando hay confianza?

When there is trust?

8—I6: Sí.

Yes.

When asked, "What (qualities) would make you trust a physician?" most interview participants responded similarly to when they were asked what qualities they seek in their physician. The themes of respect and *amabilidad* (kindness/politeness) were most prevailing. As one participant (Interview 2) stated in response to the question, "What (qualities) would make you trust a physician?":

> Que lo traten a uno con respeto…que le muestren a uno…amabilidad, ¿verdad? y el trato…

That they treat us with respect...that they show us...kindness, right? and the way they treat us...

In response to the same question, another participant (Interview 3) stated:

Pues como le digo, el español y que sean...que tengan buenos modales.

Well, like I was telling you, (that they speak) Spanish and that they be...that they have good manners.

One other participant added that her physician's understanding her would make her have more trust in her physician (Interview 6) as she stated:

Pues es lo mismo...que comprendieran a uno, que lo traten mejor, que le den confianza.

Well it's the same thing...that they understand us, that they treat us better, that they be trustworthy.

All participants of the interview portion of the study coincided in that it was very important for them to be able to trust their physician. Among the qualities which would make the participants trust their physicians, *amabilidad* (kindness) was once again the quality that was mentioned the most by participants, in addition to being treated with respect and understanding by the physician.

Definition of Trust

The interview participants' definition of trust varied, however, most participants' responses tied back into the familiar theme of being treated with respect, as one participant (Interview 6) explained:

21—Isela: Uh-huh …es dificil explicarlo ¿verdad?
Uh-huh…it's difficult to explain, right?

22—I6: Pues no se, ¡no se como explicar!
Well I don't know, I don't know how to explain!

23—Isela: Okay…un ejemplo o cualquier cosa que se le ocurra. Si un niño le preguntará '¿Qué quiere decir confianza mámi?' ¿Qué le diría usted?
Okay…(let me give) an example or it's what ever comes to you. If a little boy asked you, 'What does trust mean mommy?', what would you tell him?

24—I6: Pues es…es querer a esa persona.
Well it's…it's to love that person.

25—Isela: ¿Querer?
To love?

26—I6: Querer…
To love…

27—Isela: Andele…
Okay then…

28—I6: …y respetar. El respeto es lo que mas importa en cualquier persona para tener confianza. Si no hay respeto de esa persona…no hay confianza.
…and to respect. Respect is what matters most in any person in order to trust them. If there is no respect from that person…there is no trust.

One participant (Interview 2) defined trust as having, more than anything, to do with how you are treated, as she stated:

24—I2: Bueno…para mi…la palabra 'confianza'…pues en si encierra muchas cosas…

Well…for me…the word 'trust'…well in and of itself encompasses many things…

26—I2: …porque, este…usted ve la apariencia de la persona y…y este…y con su trato pues lo hace sentir a uno en confianza…

…because, uh…you see the appearance of a person and…and uh…and with the way they treat you well they make you feel like you can trust them…

28—I2: …porque a veces hasta con la mirada que le dan a uno de desprecio siente uno hay…si no XXX.

…because sometimes even with the way they look at you with despise one feels there…no XXX.

30—I2: Entonces este…lo hacen…yo por ejemplo, pues, eh para mi, eso es sentir la confianza, ¿verdad?

So uh…they make…me for example, well, uh for me, that is what it means to feel trust, right?

32—I2: Porque, hasta con la mirada a veces que lo miran a uno, de un modo, ya no tiene uno la confianza, ya no siente uno confianza.

Because, even with the way you are looked at sometimes when you are looked at, a certain way, you no longer have trust, you no longer feel trust.

35—Isela: …usted ¿cree que tiene que ver con el trato, entonces…la confianza?

…you think trust has to do with the way you are treated, then?

36—I2: Yo digo que tiene que ver con el trato…

I say it has to do with the way you are treated…

Another participant (Interview 3) defined trust in terms of being able to communicate her medical complaints to a physician:

38—I3: Pues tenerle confianza para decirle uno todas sus enfermedades, ¿verdad?
Well, to be trustful enough for you to tell him about all of your diseases, right?

42—I3: Porque a veces no tiene uno confianza, ¿verdad?, y pues le da a uno vergüenza, ¿verdad?
Because sometimes we are not trustful enough, right? And well we become shy, right?

47—Isela: Pero si un niño le pregunta a usted '¿Qué quiere decir confianza?' ¿qué le diría usted? ¿Qué le diría al niño?
But if a little boy asked you, 'What does trust mean?' what would you tell him? What would you tell the little boy?

48—I3: Pues, tener seguridad, ¿verdad?
Well, (I would tell him it means) to have certainty, right?

49—Isela: ¿Seguridad?
Certainty?

50—I3: Si.
Yes.

Although each participant had their own definition of the concept of trust, most of their responses coincided with the familiar theme of the importance of being treated with respect and dignity.

Chapter Four, the results section, presented the data obtained for the study from the developed survey and interview instruments. It included the descriptive statistics for the data obtained from the survey instrument including the demographics of the participants in the survey portion and the demographics of the interview participants.

Chapter Four also reported the major trends from the face-to-face interviews conducted with participants.

The participants of the survey portion of the study were mostly females born in México, between the ages of 27 and 35 years; most had at least nine years of education and had been living in the United States for at least 10 years. The participants of the interview portion where also mostly female natives of México ranging in age between 35 and 68 years; most had been living in the United States an average of 12.75 years and most had less than an elementary-level of education.

Overall, Spanish-speaking Hispanics in the study had more trust in Spanish-speaking Hispanic physicians than in non-Hispanic physicians who did not speak Spanish.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

This study is unique in that it is among the few studies which focused exclusively on primarily Spanish-speaking Hispanics who are mostly recent immigrants to the United States. Based on the results of the study, Spanish-speaking Hispanics appear to have more trust in Spanish-speaking Hispanic physicians than in non-Hispanic physicians who do not speak Spanish. Chapter Five contains a brief overview of the study design and purpose of the study; description of the sample; and data collection methods. The Conclusions section attempts to answer the research questions, while the Discussion and Implications section describes the significance of the study. Finally, the Recommendations section provides recommendations for further research.

Summary

The purpose of this study was to investigate the potential association between language concordant and ethnic concordant patient-provider relationships and Hispanic patients' trust in their provider, satisfaction with care, compliance with treatment, and perceived health outcomes.

The research design of this study consisted mostly of qualitative research methods involving a survey portion, composed of a multiple choice survey instrument, and an interview portion composed of six open-ended questions.

The study participants of the study consisted of fifty-two self-reported Hispanic patients who were monolingual Spanish-speakers or who spoke limited English. Forty–six patients participated in the survey portion while six patients participated in the interview portion of the study.

All participants were recruited from a family medicine clinic in Fort Worth, Texas. Before beginning the survey, all participants were given a letter in Spanish which explained the purpose of the study. All participants were asked if they spoke Spanish and if they considered themselves to be Hispanic; if they had been seen by a physician at the clinic within the last six months; if they could read and write in Spanish; and all participants were asked if they were over the age of 18 years old.

The survey was completed by willing participants, in the main waiting area of the clinic. Patients were mainly approached during the time before they were called in to be seen by their physician, and the patient's visit with the healthcare provider was not interrupted. The audio-recorded interviews were held in a more private area away from the main waiting area in order to ensure privacy. Interviews were not held in a completely enclosed room in order to avoid patients missing their names being called.

Conclusion

As previously stated, this study was based on the following research questions: (1) How does language concordance affect Hispanic patients' trust in their healthcare providers? (2) How does ethnic concordance affect Hispanic patients' trust in their healthcare providers? (3) How do Hispanic patients define trust and what are the

components of trust in Hispanic patients' patient-provider relationship? (4) How does language concordance affect patient satisfaction, patient willingness to return for care, patient compliance with medical treatment and recommendations, and perceived health status? (5) How does ethnic concordance affect patient satisfaction, patient willingness to return for care, patient compliance with medical treatment and recommendations, and perceived health status?

Overall, it may be concluded that Spanish-speaking Hispanics in the study seem to have more trust in Spanish-speaking Hispanic physicians than in non-Hispanic physicians who did not speak Spanish. Based upon the qualitative data obtained from both the survey instrument and the interviews, language concordance appears to positively affect Hispanic patients' trust in their healthcare providers; patients' responses indicate that language concordance promotes trust between Hispanic patients and their providers. Additionally, study participants' responses indicate that Hispanic patients in ethnic concordant physician-patient relationships also have greater trust in their providers; although it was difficult to determine to what extent ethnic concordance promotes trust when compared to having language concordance.

Patients' responses from the interview portion of the study reveal that although the concept of trust is difficult to define due to its abstract nature, Hispanic patients relate trust to being treated with dignity and respect. Study participants' responses also reveal that for Hispanic patients, the most important components of trust in the physician-patient relationship are strongly linked to having a language concordant physician and to being treated with kindness, empathy, dignity, and respect.

The descriptive statistics obtained from the participants' responses to the survey instrument demonstrate that Hispanic patients would follow their physician's instructions more carefully if their physician spoke Spanish (90.4% responded "Strongly Agree" or "Agree").

Fewer than half of participants (43.2%) responded "Strongly Agree" or "Agree" to the statement "I am less satisfied with my medical appointments when my doctor is Hispanic" implying that ethnic concordance influences Hispanic patients' satisfaction with their medical appointments. Based on participants' responses to the statement "I am more satisfied with my medical appointments when my doctor speaks Spanish" (93% responded "Strongly Agree" or "Agree"), language concordance appears to contribute more to increasing Hispanic patients' satisfaction with their medical appointments.

Over ninety-seven percent (97.5%) of participants responded "Strongly Agree" or "Agree" to the statement "I would recommend this clinic to someone due to my satisfaction with the medical care given by the Hispanic doctors of this clinic". The great percentage of positive responses for this particular item in the survey instrument may indicate the significance of physician-patient ethnic concordance in affecting Hispanic patients' satisfaction with medical care.

Additionally, over ninety percent of participants responded "Strongly Agree" or "Agree" to the each of the statements: "I would recommend this clinic to someone due to my satisfaction with the medical care given by the Spanish-speaking doctors of this clinic" (95.3% responded "Strongly Agree" or "Agree"), and "I would return to this clinic due to my satisfaction with the medical care given by the Spanish-speaking doctors

of this clinic (92.3% responded "Strongly Agree" or "Agree"). The descriptive statistics of the participants' responses to these statements not only demonstrate satisfaction with the medical care at this particular family medicine clinic but may also reveal the importance of both physician-patient language concordance and ethnic concordance in influencing Hispanic patients' willingness to return to a clinic and willingness to recommend a clinic to someone.

Ethnic concordance in the physician-patient relationship also appears to influence Hispanic patients' perception of their health status. Over seventy percent (72.5%) responded "Strongly Disagree" to the statement "My health would be worse if I had a Hispanic doctor", implying that Hispanic patients do not perceive having a Hispanic physician as negatively affecting their health status.

Discussion and Implications

The importance of patient trust in the physician-patient relationship is an understudied topic which has gained increasingly more focus in research. Some studies attribute the growing concern with trust in the physician-patient relationship to the rise of managed care (Thom & Campbell, 1997; Pearson & Raeke, 2000). However, the rapid growth of immigrant populations in the United States, especially that of the Hispanic population, in conjunction with rising rates of medically uninsured persons, may also contribute to the increasing focus on the importance of trust in the patient-provider relationship within research (Doty, 2003).

Doty (2003) reported that almost fifty percent (46%) of Hispanic adults lacked health insurance for all or part of 2001. The high rates of uninsured Hispanics in the U.S. pose negative implications in terms of trust in the physician-patient relationship. Studies have revealed that a lack of health insurance limits patients' choice of where they are able to receive medical care (Doty, 2003), thus hindering continuity with a provider, which in turn impedes patients from forming trusting physician-patient relationships. (Thom & Campbell, 1997; Doescher et al., 2000; Pearson & Raeke, 2000; Baker, 2003; Doty, 2003; Mainous et al., 2003). Baker et al. (2003) reports that discontinuity with a provider, in fact, diminishes the opportunity for trust to develop. Furthermore, studies have revealed that having health insurance may actually contribute to increasing trust in the physician patient relationship (Mainous et al. 2001; Doty, 2003).

Mainous et. al. (2003) has described trust as "a central element in the doctor-patient relationship". Trust in the physician-patient relationship has been found to be associated with various health-related factors including patient satisfaction with medical encounters and medical care (Doescher et al., 2000; Baker et al., 2003; Doty, 2003); patient compliance with medical treatment (Thom & Campbell, 1997; Doescher et al., 2000; Mainous et al, 2003); and continuity of care with provider (Doescher et al., 2000; Mainous et al., 2000; Baker et al., 2003).

Among the most important goals of this study was to determine what Hispanic patients consider to be the principal components of trust in the physician-patient relationship. Few studies have examined components of trust in the physician-patient relationship. According to a study by Pearson & Raeke (2000), competence, compassion,

privacy and confidentiality, reliability and dependability, and communication are the most commonly described qualities in a physician on which patients base their trust. Furthermore, as previously mentioned in the review of the literature in Chapter Two, the study by Thom & Campbell (1997) which examined the components of trust in the physician-patient relationship revealed that important dimensions of trust in the physician-patient relationship include mutual understanding, caring, communication, and respect for patient autonomy.

Study participants' responses in the interview indicate that two the most prominent qualities that Hispanic patients seek in a physician are language concordance and *amabilidad* or kindness which is related to the rapport or "bedside manner" of a physician. Being treated with respect and attentiveness by the physician were also qualities considered by study participants to be important. Moreover, the qualities patients perceived as trust-enhancing were, once again, *amabilidad* and understanding by the physician. Hispanic patients' definition of trust appears to be tightly linked to being treated with dignity and respect, as one patient so clearly stated: "Respect is what matters most in any person in order to trust them. If there is no respect from that person...there is no trust" (Interview 6). *Respeto* or respect is a major component of Hispanic culture (Huff & Kline, 1999) which it greatly influences Hispanic patients' satisfaction with their medical encounters and influences trust in their physician, as indicated by the qualitative data obtained through this study. Collins, Hughs, Doty, Ives, Edwards, and Tenney (2002) reported that Hispanic patients were most likely to feel that they had been treated with disrespect during a healthcare visit and that this was tied to the patients' perception

that he or she was spoken to rudely, talked down to, or ignored. The finding by Collins et. al. (2002) serves to further emphasize the importance of respect for Hispanic patients in the physician-patient relationship.

The qualitative data obtained through this study stresses the importance of physicians' rapport with patients in building trust in the physician-patient relationship, especially with Hispanic patients who are primarily Spanish-speaking.

It was difficult to determine whether language concordance or ethnic concordance was a more important factor influencing Hispanic patients' trust in their physician. The majority of participants (90.9%) in the survey portion of the study responded "Agree" or "Strongly Agree" in response to the statement "I have more trust in a Hispanic doctor who speaks Spanish than in a Hispanic doctor that does not speak Spanish". Over eighty percent (81.4%) of participants, on the other hand, responded "Agree" or "Strongly Agree" to the statement "I have as much trust in a non-Hispanic physician that speaks Spanish as in a Hispanic physician that does not speak Spanish". Additionally, analysis of the association between the two variables "I have more trust in a Hispanic doctor who speaks Spanish than in a Hispanic doctor that does not speak Spanish" and "I have as much trust in a non-Hispanic physician that speaks Spanish as in a Hispanic physician that does not speak Spanish" were statistically significant ($p<0.01$), indicating an association between the two variables.

It is possible that Hispanic patients believe it is equally important for their physician to be Hispanic and speak Spanish (88.1% responded "Agree" or Strongly Agree") based on the descriptive statistics obtained from the participants' responses to the survey

instrument. Furthermore, the analysis of the association between the variables "It is equally important for my doctor to be Hispanic and speak Spanish" and "I would keep my appointments more often if my physician spoke Spanish" was also statistically significant ($p<0.01$), indicating an association between the two variables.

It is important to take into account the fact that this study was completely based on patients' responses and they may not be accurate in terms of the participants' actual perceptions. As mentioned in Chapter One, questions could have been misinterpreted and it is possible that redirecting the questions purposely in order to help avoid response bias, may have confused some patients.

Furthermore, the setting of the site of data collection, a busy family medicine clinic, may have significantly affected patients' responses due to the noise level in the waiting area where the survey was completed. Participants were constantly awaiting the calling of their name in order to be seen by the physician and this may have lead to a high level of distraction for the patient and may have kept the patient from fully paying attention to the questions of the survey instrument and from giving each question sufficient thought before responding. Moreover, response bias may have negatively affected the validity of the data collected since participants may have a tendency to respond positively to every question without regard to the actual content of the question.

Additionally, it is important to note that the small sample size may have contributed to the level of significance of most of the results.

Recommendations

To date there are a scarce number of studies focusing exclusively on primarily Spanish-speaking Hispanics who are recent immigrants. The literature reviewed demonstrates that studies which have included Hispanic participants have rarely included primarily Spanish-speaking Hispanics and rarely have they developed study instruments in Spanish enabling the inclusion of Spanish-speaking Hispanics in studies focusing on Hispanic patients and the physician-patient relationship.

This study focused exclusively on Hispanic patients whose primary language is Spanish and who are mostly recent immigrants to the United States. Studies indicate that the needs of English-speaking Hispanics and of Spanish-speaking Hispanics who are recent immigrants are different. Various studies have found that Hispanics in the U.S. as whole suffer similar inequities, such as disproportionately low rates of health insurance, lower educational attainment, and lower socio-economic status in general (Collins et al. 2002; Doty 2003). In the study by Doty (2003), for instance, it was revealed that two of five Hispanics ranging in age between 19 and 64 years were lacking health insurance in the year 2000, including both Spanish-speaking and English-Speaking Hispanics. Collins and colleagues (2002) found that nearly four out of ten Hispanics in the U.S. have less than a high school education compared to only one out of every ten whites. Furthermore, Collins et al. (2002) found that almost one of three Hispanics reported having incomes that were below the federal poverty level (approximately $18,000 for a family of four).

Nonetheless, studies have also revealed, that English–speaking Hispanics in the U.S. when compared to primarily Spanish-speaking Hispanics, are more likely to be

insured (Doty 2003) and more likely to understand their doctor's instructions (David, 1998 as cited in Cooper & Powe, 2004). In further validation of the finding by David (as cited in Cooper & Powe, 2004), Doty (2003) also reported that Hispanics with limited English proficiency (45%) are more likely to have problems communicating with their physician than Hispanics who speak English primarily (27%). Doty (2003) found that Spanish-speaking Hispanics (61%) were significantly more likely to be lacking health insurance during the year than English-speaking Hispanics (36%).

More studies are needed which focus on primarily Spanish-speaking Hispanic patients which have slightly different needs than English-speaking Hispanics in the U.S. due not only to the language factor, but also due to cultural differences. Most primarily Spanish-speaking Hispanics were born in Latin-American countries while most primarily English-speaking Hispanics were born and or raised in the United States. Therefore, acculturation differences must be taken into consideration as well when determining the healthcare needs of Hispanics in the United States.

More studies should also focus on determining what primarily Spanish-speaking Hispanics consider to be the most important components of trust in the physician-patient relationship. More qualitative data, such as focus groups with Spanish-speaking Hispanics in particular, may bring to light more conclusive information about what Hispanic patients consider the most important component of having trust in their physician.

The final recommendation that can be made is that the number of Hispanic, Spanish-speaking physicians should be increased. In the State of Texas, for instance, a

report from the Texas Department of State Health Services states that the growth in the number of minorities entering health professions is not increasing as rapidly as the growth in the minority population in Texas (Texas Department of State Health Services, 2005). While the Hispanic population of Texas increased from 32% in 2000 to 35.4% in 2005, the percentage of Hispanic physicians only increased by 6.2% (Health Professions Resource Center—Texas Department of State Health Services, 2006). Specifically in Tarrant County, the Texas Medical Board reported that out of the 3031 physicians in the county for 2007, only 5.1% were Hispanic compared to 72.3% of white physicians (Texas Medical Board, 2007). Thus, although the percentage of Hispanic physicians in Texas has increased since the year 2000, there continues to be a disproportionate number of Hispanic physicians to the number of Hispanics in the state, particularly in Tarrant County.

There is sufficient evidence in the literature which demonstrates the positive impact that language and ethnic concordant physicians have on the satisfaction and health outcomes of Hispanic Spanish-speaking patients. Flores and Mendoza et al. (2002) suggest that in order to increase the number of current and future Spanish-speaking physicians, medical schools in states with large Hispanic populations must make medical Spanish classes mandatory and should offer ongoing Spanish courses for residents and attending physicians. Additionally, Flores and Mendoza et al. (2002) suggest that the numbers of Latino health care professionals should also be increased in order for the numbers to be proportional to the number of Hispanics in the general population. The authors also make the very relevant comment that health care institutions must ensure

that all patients who speak limited English have access to trained interpreters (Flores & Mendoza et al., 2002).

The findings from this study as well as current statistics indicate a need for more Hispanic, Spanish-speaking and culturally competent physicians to serve the needs of Hispanic patients in the United States. Congress, the medical community, and minority patient advocacy groups must all cooperate in order to implement strategies to help eliminate language and ethnic barriers in health care and to make health care delivery more equitable in the United States.

REFERENCES

APA Citation Style. (2002). Retrieved on July 15, 2007 from http://www.library.cornell.edu/newhelp/res_strategy/citing/apa.html

Baker, D.W., Hayes, R., Puebla-Fortier, J. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. Medical Care, 36, 10, 1461-1470.

Baker, R., Mainous, A.G., Gray. D.P., Love, M.M. (2003). Exploration of the relationship between continuity, trust in regular doctors and patient satisfaction with consultations with family doctors. Scandinavian Journal of Primary Health Care, 21, 27-32.

Barkin, S., Balkrishnan, R., Manuel, J., Hall, M.K. (2003). Effect of language immersion on communication with Latino patients. North Carolina Medical Journal, 64, 6, 258, 262.

Bell, R.A., Kravitz, R.L., Thom, D., Krupat, E., Azari, R. (2002). Unmet expectations for care and the patient-physician relationship. [Electronic version]. Journal of General Internal Medicine, 17, 817-824.

Carrasquillo, O., Orav, J., Brennan, T.A., Burstin, H.R. (1999). Impact of language barriers on patient satisfaction in an emergency department. [Electronic version]. Journal of General Internal Medicine, 14, 82-87.

Census 2000 Brief: Language Use and English Speaking Ability. (2000). Retrieved on September 8, 2004 from http://www.census.gov/prod/2003pubs/c2kbr-29.pdf

Citing References: APA Style (5th ed.). (2006). Retrieved on July 15, 2007 from http://library.uww.edu/GUIDES/APACITE.htm

Clark, T., Sleath, B., & Rubin, R.H. (2004). Influence of ethnicity and language concordance on physician—patient agreement about recommended changes in patient health behavior. Patient Education and Counseling, 53, 87-93.

Collins, K.S., Hughs, D.L., Doty, M.M., Ives, B.L., Edwards, J.N., Tenney, K. (2002). Diverse communities, common concerns: Assessing health care quality for minority Americans. [Electronic version]. The Commonwealth Fund, #523.

Cooper, L.A., & Powe, N.R. (2004). Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic, and language concordance. [Electronic version]. The Commonwealth Fund, #753.

Cooper, L.A., Roter, D.L., Johnson, R.L., Ford, D.E., Steinwachs, D.M., Powe, N.R. (2003). Patient centered communication, ratings of care, and concordance of patient and physician race. Annals of Internal Medicine, 139, 11, 907-915.

Cooper-Patrick, L., Gallo, J.J., Gonzales, J.J., Vu, H.T., Powe, N.R., Nelson, C., Ford, D.E. (1999). Race, gender, and partnership in the patient-physician relationship. [Electronic version]. Journal of the American Medical Association, 282, 6, 583-589.

Doescher, M.P., Saver, B.G., Franks, P., Fiscella, K. (2000). Racial and ethnic disparities in perceptions of physician style and trust. [Electronic version]. Archives of Internal Medicine, 9, 1156-1163.

Doty, M.M. (2003). Hispanic patients' double burden: Lack of health insurance and limited English. [Electronic version]. The Commonwealth Fund, #592.

Enguidianos, E.R. & Rosen, P. (1997). Language as a factor affecting follow-up compliance from the emergency department. [Electronic version]. The Journal of Emergency Medicine, 15, 1, 9-12.

Ferguson, W.J. & Candib, L.M. (2002). Culture, language, and the doctor—patient relationship. [Electronic version]. Family Medicine, 34, 5, 53-61.

Fernández, A., Schillinger, D., Grumbach, K., Rosenthal, A., Stewart, A.L., Wang F., Pérez-Stable, E. (2004). Physician language ability and cultural competence: An exploratory study of communication with Spanish-speaking patients. [Electronic version]. Journal of General Internal Medicine, 19, 167-174.

Flores, G., Mendoza, F.S. (2002). ¿Dolor Aquí? ¿Fiebre? A little knowledge requires caution. [Electronic version]. Archives of Pediatrics & Adolescent Medicine, 156, 7, 638-640.

García, J.A., Paterniti, D.A., Romano, P.S., Kravitz, R.L. (2003). Patient preferences for physician characteristics in university-based primary care clinics. Ethnicity & Disease, 13, 259-267.

Gray, B., & Stoddard, J.J. (1997). Patient-physician pairing: does racial and ethnic congruity influence selection of a regular physician?. [Electronic version]. Journal of Community Health, 22, 4, 247-259.

Hall, M.A., Dugan, E., Zheng, B., Mishra, A.K. (2001). Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? The Milbank Quaterly, 79, 4, 613-639.

Hall, M.A., Zheng, B., Dugan, E., Camacho, Kidd, K.E., Mishra, A., Balkrishnan, R. (2002). Measuring patients' trust in their primary care providers. Medical Care Research & Review, 59, 3, 293-318.

Health Personnel for the State of Texas and Council of Government Regions in Texas in 2000 and Projections for 2010 and 2040 Using the Population Projection That Assumes Rates of Net Migration, Texas Department of Health, Health Professions Resource Center (Online). (2002). Retrieved on January 10, 2007, from http://txsdc.utsa.edu/pubsrep/pubs/txchalcog/cogtab5-28.txt

Hillman, A.L. (1998). Mediators of patient trust. [Electronic version]. Journal of the American Medical Association, 280, 19, 1703-1705.

Highlights: The Supply of Primary Care Physicians in Texas-2005. (2006). Retrieved July 1, 2007, from http://www.dshs.state.tx.us/CHS/hprc/PCphys.pdf

Huff, R.M., Kline, M.V. (1999). Promoting Health in Multicultural Populations: A Handbook for Practitioners. Thousand Oaks, CA: Sage Publications, Inc.

Komaromy, M., Grumbach, K., Drake, M., Vranizan, K., Lurie, N., Keane, D., Bindman, A.B. (1996). The role of black and Hispanic physicians in providing care for underserved populations. [Electronic version]. The New England Journal of Medicine, 334, 20, 1305-1310.

Lasser, K.E., Mintzer, I.L., Lambert, A., Cabral, H., Bor, D.H. (2005). Missed appointment rates in primary care: The importance of site of care. Journal of Health Care for the Poor and Underserved, 16, 475-486.

Laveist, T.A, & Nuru-Jeter, A. (2002). Is doctor-patient race concordance associated with greater satisfaction with care?. Journal of Health & Social Behavior, 43, 3, 296-306.

Lee, L.J., Batal, H.A., Maselli, J.H., Kutner, J.S. (2002). Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. [Electronic version]. Journal of General Internal Medicine, 17, 641-646.

Mainous, A.G., Baker, R., Love, M.M., Gray, D.P., Gill, J.M. (2001). Continuity of care and trust in one's physician: Evidence from primary care in the United States and the United Kingdom. Family Medicine, 33, 1, 22-7.

Mainous, A.G., Kerse, N., Brock, C.D., Hughs, K., Pruitt, C. (2003). Doctors developing trust: Perspectives from the United States and New Zealand. New Zealand Family Practice, 30, 336-341.

Manson, A. (1988). Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. Medical Care, 26, 12, 1119-1128.

Mazor, S.S., Hampers, L.C., Chande, V.T., Krug, S.E. (2002). Teaching Spanish to pediatric emergency physicians: effects on patient satisfaction. Archives of Pediatric & Adolescent Medicine, 156, 693-695.

McGoldrick, M., Giordano, J. (1996). Overview: Ethnicity and family therapy. In McGoldrick, M., Giordano, J., Pearce, J.K. Ethnicity and Family Therapy. New York, NY: The Guilford Press; 1-27.

McGoldrick, M. (1982). Ethnicity and family therapy: An overview. In M. McGoldrick, J.K. Pearce, J. Giordano (Eds), Ethnicity and Family Therapy (1st ed., pp3-30). New York: Guilford Press.

Morales, L.S., Cunningham, W.E., Brown, J.A., Liu, H., Hays, R.D. (1999). Are Latinos less satisfied with communication by health care providers?. [Electronic version]. Journal of General Internal Medicine, 14, 7, 409-417.

Murray-García, J.L., García, J.A., Schembri, M.E., Guerra, L.M. (2001). The service patterns of a racially, ethnically, and linguistically diverse housestaff. Academic Medicine, 76, 12, 1232-1240.

Murray-García, J.L., Selby, J.V., Schmittdiel, J., Grumbach, K., Quesenberry, C. (2000). Racial and ethnic differences in a patient survey: Patients' values, ratings, and reports regarding physician primary care performance in a large health maintenance organization. Medical Care, 38, 3, 300-310.

Oliver, M.N., Goodwin, M.A., Gotler, R.S., Gregory, P.M., Stange, K.C. (2001). Time use in clinical encounters: Are African-American patients treated differently? Journal of the National Medical Association, 93, 10, 380-385.

Pearson, S.D. & Raeke, L.H. (2000). Patients' trust in physicians: Many theories, few measures, and little data. [Electronic version]. Journal of General Internal Medicine, 15, 509-513.

Pérez-Stable, E. J., Nápoles-Springer, A, Miramontes, J.M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. Medical Care, 35, 12, 1212-1219.

Radina, M.E., Armer, J.M., Culbertson, S.D., Dusold, J.M. (2004). Post-breast cancer lymphedema: Understanding women's knowledge of their condition. Oncology Nursing Forum, 31, 1, 97-104.

Rivadeneyra, R., Elderkin-Thompson, V., Silver, R.C., Waitzkin, H. (2000). Patient centeredness in medical encounters requiring an interpreter. [Electronic version]. American Journal of Medicine, 108, 470-474.

Sangillo, Gregg. (2002). Who's Hispanic?. [Electronic version]. National Journal, 34, 23, 1699-1701.

Saha, S., Arbelaez, J.J, & Cooper, L.A. (2003). Patient—physician relationships and racial disparities in the quality of health care. [Electronic version]. American Journal of Public Health, 93, 10, 1713-1719.

Saha, S., Komaromy, M., Koepsell, T.D., Bindman, A.B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. [Electronic version]. Archives of Internal Medicine, 159, 997-1004.

Saha, S., Taggart, S.H., Komaromy, M., Bindman, A.B. (2000). Do patients choose physicians of their own race?. [Electronic version]. Health Affairs, 19, 4, 76-83.

Seijo, R., Gomez, H., Freidenburg, J. (1991). Language as a communication barrier in medical care for Hispanic patients. Hispanic Journal of Behavioral Sciences, 13, 4, 363-376.

Selected Health Professions in Texas 2004. (2005). Retrieved on July 1, 2007, from http://www.dshs.state.tx.us/CHS/hprc/Intro04.pdf

SPSS FAQ: How do I interpret the results from crosstabs?. (n.d.). Retrieved on June 18, 2007, from http://www.ats.ucla.edu/STAT/SPSS/faq/xtab_int.htm

Stevens, G.D., Shi, L., Cooper, L. A. (2003). Patient-Provider racial and ethnic concordance and parent reports of the primary care experiences of children. [Electronic version]. Annals of Family Medicine, 1, 2, 105-112.

Tarrant County QuickFacts from the U.S. Census Bureau. (2000). Retrieved on October 27, 2005 from http://quickfacts.census.gov/qfd/states/48/48439.html

Texas Medical Board, Reports and Statistics, Physicians by Ethnicity and County, January 2007. (2007). Retrieved on July 1, 2007 from http://www.tmb.state.tx.us/agency/statistics/demo/docs/d2007/0107/ethnic.php

Thom, D.H., & Campbell, B. (1997). Patient-physician trust: an exploratory study. Journal of Family Practice, 44, 2, 69-76.

van Wieringen, J.C.M., Harmsen, J.A.M., Bruijnzeels, M.A. (2002). Intercultural communication in general practice. European Journal of Public Health, 12, 1, 63-68.