Published in final edited form as:

Female Pelvic Med Reconstr Surg. 2013 ; 19(3): . doi:10.1097/SPV.0b013e318288ac1c.

Communication Barriers among Spanish-speaking Women with Pelvic Floor Disorders: Lost in Translation?

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Abstract

Objectives: The purpose of our study was to evaluate barriers in communication and disease understanding among office staff and interpreters when communicating with Spanish-speaking women with pelvic floor disorders.

Methods: We conducted a qualitative study to evaluate barriers to communication with Spanish-speaking women with pelvic floor disorders among office staff and interpreters. Sixteen office staff and interpreters were interviewed; interview questions focused on experiences with Spanish-speaking patients with pelvic floor disorders in the clinic setting. Interview transcripts were analyzed qualitatively using grounded theory methodology.

Results: Analysis of the interview transcripts revealed several barriers in communication as identified by office staff and interpreters. Three major classes were predominant: patient, interpreter, and system-related. Patient-related barriers included 1) a lack of understanding of anatomy and medical terminology and inhibited discussions due to embarrassment. Provider-related barriers included poor interpreter knowledge of pelvic floor vocabulary and the use of office staff without interpreting credentials. System-related barriers included poor access to information. From these preliminary themes, an emergent concept was revealed: it is highly likely that Spanish-speaking women with pelvic floor disorders have poor understanding of their condition due to multiple obstacles in communication.

Conclusions: There are many levels of barriers to communications with Latinas treated for pelvic floor disorders, arising from the patient, interpreter, and the system itself. These barriers contribute to a low level of understanding of their diagnosis, treatment options, and administered therapies.

Keywords

pelvic prolapse; urinary incontinence; disease understanding; underserved Latinas

INTRODUCTION

The burden of pelvic floor disorders is immense in human terms and continues to rise with the growing population of older adults. A recent epidemiological study of 1,961 women found the prevalence of at least one pelvic floor disorder in women over age 20 to be 23.7%¹. Specifically, 15.7% complained of urinary incontinence, 9% complained of fecal incontinence, and 2.9% had pelvic organ prolapse. The prevalence of pelvic floor disorders increases with age from 9.7% among women age 20 to 39 to 49.7% of those over the age of 80. Wu et al. estimate that the number of women in the U.S. with at least one pelvic floor disorder will increase from 28.1 million in 2010 to 43.8 million in 2050². During this time period, the incidence of pelvic organ prolapse will increase by 46% and UI by 55%.

Prevalence of pelvic floor dysfunction varies among different ethnicities, particularly between Hispanic and non-Hispanic populations. Latinas bear a disproportionate burden from symptomatic pelvic floor disorders. A population-based cohort study comparing 2,270 African American, Caucasian, and Latina females showed a 4-5 times higher rate of symptomatic pelvic organ prolapse in Caucasian and Latina women compared to African American females³. Higher rates of urinary incontinence among the Latina population compared to non-Hispanic white females have also been demonstrated, with a 1.7 times increased rate of stress urinary incontinence (SUI) and 1.8 times increased rate of mixed incontinence⁴.

Patient-related and system-related barriers to medical care for Latina patients have been identified for many conditions, including follow-up of abnormal PAP smears and mammograms^{5,6}. Inadequate communication between physicians, staff and patients is one such barrier that is particularly important for this population. Latinas reported that their healthcare providers engage in five important communication tasks with less frequency than non-Hispanic white women⁷ and Spanish speaking Latino/as in particular report higher levels of dissatisfaction with the provider communication they receive⁸. Inadequate communication can result in a variety of poor outcomes⁹. Although this barrier has been studied in a variety of populations¹⁰⁻¹², it is unknown whether such barriers exist for women with pelvic floor disorders. We sought to define such barriers by interviewing interpreters and office staff who regularly interact with Spanish-speaking women presenting with pelvic floor disorders.

MATERIALS & METHODS

Approval was obtained from the UCLA Institutional Review Board. All interviews were de-identified, therefore consent was waived. Office staff (N=11) employed in a female urology sub-specialty clinic and certified hospital-based interpreters (N=5) were interviewed. Hospital-based interpreters were asked about their interactions with Spanish-speaking Latinas and their experiences in the clinic setting. A standardized interview script with open-ended questions was used. Interviews were de-identified, recorded, and transcribed verbatim.

Qualitative analysis was used to analyze the data, as these methods are justified in areas of research where little knowledge exists. Grounded theory, first developed in 1967, was used to analyze interview data¹³. Grounded theory guides analysis at several points in the research process by collecting and analyzing data qualitatively. A central concept in grounded theory is to obtain a broad range of perspectives or experiences that relate to the study question. Often interviews, focus groups, journals, surveys, or field observations are utilized to obtain data. It is best used in studies conducted in social settings and to develop a theory or process, rather than to test a hypothesis as is done in quantitative research. Instead,

the researcher searches for a theory implicit in the data using an “iterative approach,” several stages of data collection and analysis subsequently guide the next step in the study¹⁴. Key issues are identified by coding and finding categories. This includes line-by-line coding of transcripts in which key phrases are identified in the patient’s own words. Similarly coded phrases are then grouped together to create clusters^{15,16}. From these, preliminary themes are combined to develop categories. Finally, these themes are evaluated to derive core categories or emergent concepts

In our study, four individual investigators independently performed line-by-line coding of the transcripts from the interviews with the office staff and interpreters to minimize subjectivity. They also applied the technique of grounded theory of theoretical sampling in which theory is generated as it emerges through ongoing data collection¹⁷. Themes were derived from the line-by-line coding by each investigator, and then the derived preliminary themes were then compared and merged.

RESULTS

Sixteen interviews were conducted. Ten of the office staff were women, all of Hispanic origin, and one was male. All were certified nurses and had been working in the urology clinic for several years. Three male and two female hospital-based interpreters were interviewed. Both office staff and hospital-based interpreters were fluent in both Spanish and English and had passed a medical translation certification exam. Four of the hospital-based interpreter interviews were through a telephone service and provided services to non-medical specialties as well. One worked primarily in a hospital setting. Each interview lasted approximately twenty minutes. After independent review by four investigators, several preliminary themes emerged, which were further classified into three broad categories of barriers to Latina communication present at the level of the patient, the provider, and within the system as reported by office staff and interpreters (Figure 1).

Patient-related Barriers

Patient-related barriers included a generally poor understanding of medical conditions, pelvic anatomy, and specific pelvic floor disorder by Latina patients. In terms of their general health, interpreters and office staff stated that Spanish-speaking Latinas often did not often know the names, purposes of, or side effects of their medicines (Figure 2). They had a tendency to bring all their medicine bottles in for the clinician to review. In comparison, English-speaking women would usually know the medications they were on or have a list. Pelvic anatomy was poorly understood, often requiring hand motions in order to describe what body part is affected. Additionally, medical paperwork questionnaires in English were at times inaccurately answered. For example, some patients stated that they have either all or none of the listed medical conditions on the initial paperwork. However, even when the paperwork was translated for the patient by office staff, there appeared to be a general lack of knowledge of their comorbidities.

There was also a lack of knowledge of medical terminology. Hand motions were often required to illustrate pelvic anatomy and to describe phrases or terms that the patient did not know how to say. Compared with English-speaking patients, Spanish-speaking patients tended to describe everything in great detail and disclose all their symptoms to interpreters, including front office staff. For example, when making an appointment they would state to the front office staff that they leaked with cough. As stated by interpreters and office staff, “English-speaking patients will just say stress incontinence or urinary incontinence,” and “I haven’t encountered a Spanish-speaking patient that uses those terms.”

The lack of knowledge was often embarrassing for patients, as they did not want to appear unable to understand. Even when asked, many of them did not disclose a lack of understanding, even though later some would ask office staff for clarification after the clinic visit. Compared with English-speaking patients, Latina patients tended to ask fewer questions prior to deciding on particular treatment. One office staff member states, “The patients that don’t speak English say ‘yes’ to everything that you tell them. And when I ask them, ‘Do you understand?’ they always say ‘yes.’ To me, I don’t feel that they completely understand.” There was a lack of questioning of providers, as well as a low level of involvement in the decision-making for treatments.

The need to discuss “taboo” topics in detail contributed to embarrassment in engaging in discussions about pelvic floor disorders. At times, Latinas confided more to the Spanish-speaking office staff than to the clinician. Latina bilingual office staff raised in primarily Spanish-speaking homes stated that these topics were not openly discussed during their own upbringings. They recognized that this prevented them from learning necessary medical terminology.

Finally, in addition to the time needed for translation, office staff reported that Spanish-speaking patients required more time than English-speaking patients during many points of the clinic visit. This resulted in a greater time requirement per Spanish-speaking patient for the office staff. Prior to the clinic visit, office staff were often required to help translate and fill out the medical paperwork. When patients called to schedule appointments, many of them did not know the reason for referral and called only because they were told by their primary care physicians to see a specialist. The front office staff were often required to search through other documents to define the chief complaint or identify the reason for referral. Patient phone calls also required more interviewing and questioning than with English-speaking patients in order to best help the patients for purposes of triage.

Despite these patient-related barriers, Spanish-speaking females were found to be proactive in seeking out Spanish-speaking personnel. One interpreter stated, “Their first words are, ‘Do you speak Spanish?’” or “Sometimes patients ask if the doctors will speak Spanish before they even go in. They’ll ask ahead of time if the doctor speaks Spanish.” Often an English-speaking family member calls for them for further questions or clarifications.

Provider-related Barriers

Provider-related barriers were present at the level of the clinician, bilingual office staff, and certified hospital-based interpreters. Clinician-based barriers centered around the use of non-credentialed office staff as interpreters. Often time was required of them in addition to their normal clinic duties. They were also less likely to inquire about words they did not understand compared with certified interpreters.

Barriers at the level of the office staff were present when required to play the role of a clinician. The office staff were often asked detailed questions by patients regarding their symptoms, treatment options, and medications. They often had to piece together the patients’ symptoms and prior medical history in order to obtain information about the chief complaint. Latina patients often disclosed all of their symptoms to the staff, unlike English-speaking patients. As described by a front office staff member, “Sometimes they call in and say, ‘I don’t know why I’m being referred,’ and so then I ask ‘What are your symptoms?’ and then we go from there.”

Patients were also stereotyped by office staff as less capable of understanding their conditions. On the contrary, however, some interpreters assumed that patients understood the condition or words being used without clarifying that they did in fact understand. Most

office staff and interpreters had a poor understanding of the medical conditions being interpreted. For example, when asked the definition for stress incontinence, one of the bilingual office staff replied, “Stress incontinence? Isn’t that when women leak urine when they are in a stressful situation in their lives?” However, there was an assumption on the part of both credentialed interpreters and office staff that there was no discrepancy in communication, and neither group was aware of the effect of this on the effectiveness of their interpreting. A front office staff member, with a notable lack of pelvic floor vocabulary, such as knowing the translated words for ‘cystocele,’ ‘sling,’ or ‘incontinence,’ said, “I know the old school Spanish so most likely when we have a patient that calls in, I understand them perfectly.” Another stated, “I’ve been here quite a few years; I have a system of interpreting.”

A common preliminary theme present within each barrier was a lack of knowledge of Spanish medical terminology related to pelvic floor disorders by all parties involved: the patient, the clinician, and the interpreter. The terminology is present within Spanish medical dictionaries, but when office staff and interpreters are queried about these terms during the interviews, the words are unrecognized. In general, in order to discuss a symptom, diagnosis or treatment plan, descriptions of the condition are used rather than the actual name of the condition.

System-related Barriers

Interpreters and office staff identified a number of system-related barriers that included a lack of information and education tools, a lack of Spanish paperwork, as well as limited vocabulary within the medical community to describe the conditions associated with pelvic floor disorders. In offices with a predominant population of English-speaking patients, there was often a paucity of written literature in Spanish, further contributing to disparities in understanding between English and Spanish-speakers. Interviewees identified that many patients did not have access to computers or did not understand how to use them. As compared to English-speaking patients who at times brought printouts and pamphlets from their own research, Spanish-speaking patients lacked additional Rplementary information.

DISCUSSION

With a rapidly increasing Hispanic population within the United States, there is a need to understand and optimize our communication techniques with this patient population to afford them the same access to care provided to English-speaking women. Routes of communication with an English-speaking patient are usually directly by the provider or by various informational tools. In contrast, Spanish-speaking patients do not have a direct form of communication with English-speaking physicians, and instead require additional parties or steps in order to receive the same information. Ideally, this is provided by either the use of a certified interpreter or by translated forms. However it is quite common to utilize the aid of a non-certified bilingual interpreter in the form of a family member, office staff member, nurse, or other personnel in the medical center. Each of these additional steps serves as a potential barrier to optimal communication with Spanish-speaking patients (Figure 3).

Language barriers have a well-studied association with health disparities. They have been shown to increase length of hospital stay¹⁸, contribute to poor understanding of medications and side effects¹⁹, promote poorer compliance with medications²⁰, increase medical errors and misdiagnoses^{21,22}, and limit access to preventative care²³. There has also been shown to be greater dissatisfaction with care¹⁹. When interpreter services are used, there has been found to be increased satisfaction²⁴ as well as improved outcomes²⁵. Unfortunately, there is a significant under-utilization of interpreter services²⁶, despite the fact that Latina patients

provided interpreter services fill more prescriptions, are provided more preventative services, and make more office visits²⁷.

Effects on communication by both language barriers and health literacy have been established. Health literacy, as defined by the U.S. Institute of Medicine is defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions²⁸.” Sudore et al. evaluated communication between physicians and 771 patients and found the greatest discrepancy in ability to communicate existed between a non-Spanish-speaking physician and a Spanish-speaking patient²⁹. Language barriers were the primary source of discordance, however, health literacy had a significant influence on effective communication as well. A study by Percac-Lima found that Mexican-American women with poor health literacy, compared to those with adequate health literacy, were less likely to undergo screening mammography⁵.

Nutbeam developed a model in which health literacy is a recognizable risk factor that can affect clinical outcomes. In this model, a prior assessment of the level of knowledge and reading literacy needs to be ascertained, thereby helping to develop a clinical environment conducive to proper communication to enhance the quality of the patient-provider interaction³⁰. According to D.W. Baker, there are few tools to assess the level of knowledge, which is an important component of assessing health literacy³¹. Given the significance and prevalence of pelvic floor disorders among the Latina population, our goal was to identify obstacles in communication that prevent Latinas of varying literacy from achieving knowledge. Our study revealed three main categories of barriers to communication between providers and Spanish-speaking Latinas with pelvic floor disorders as identified by Spanish-speaking interpreters and office staff: patient-related, provider-related, and system-related. Each of these has a high likelihood of affecting understanding of disease processes and treatment plans.

Identified patient-related barriers included a poor general understanding of medical conditions and anatomy as well as a lack of knowledge of the medical terminology. It seemed that a majority of the problems were centered around a lack of English fluency and a lack of literacy. Latinas often incorrectly filled out medical questionnaires, which may in part be due to an inability to understand the paperwork, or may be due to a poor understanding of their medical history. This may be due to a lack of teaching by primary medical specialties, or it may stem from cultural restraints and norms. Often, the home setting does not provide opportunity to have open discussion regarding matters of the genitourinary tract and pelvic floor disorders. Other possible reasons for the discrepancy noted between Latinas and whites may be due to differences in culture, educational background, or access to technologies or resources that educate women on health issues. Latinas tended to confide more in the female office staff than the clinician, possibly because they are more comfortable discussing pelvic floor issues with a native female speaker. Additionally, both the lack of understanding and embarrassment stemming from the desire to appear knowledgeable may be contributing factors to the lack of involvement in the clinical decision-making. Many of these factors attributed to each patient requiring more time by the office staff. This puts greater strain on the staff to complete their normal duties, as well as thoroughly assist their patients.

Provider-related barriers existed at the level of the clinician, non-certified office staff, and hospital-based interpreters. The clinician's use of office staff as interpreters posed many problems. First, many of them were not credentialed and were less likely to clarify or inquire about the material they were asked to discuss than certified interpreters were. This may be because there is an expectation for them to have a baseline understanding of the conditions

and terminology because of their employment in a urology clinic, despite not having any formal training or orientation in the specialty. Just as with the patients' need to gesture in order to communicate, descriptions and hand motions from the office staff were also reported to be used in order to communicate rather than using known medical terminology. It is unclear whether this is due to a lack of knowledge of the terms or if it due to stereotyping that Latinas would not be able to understand if hand motions were not used. In either case, this may propagate the lack of use of medical terminology by preventing the introduction of the terminology into the Spanish-speaking community. It is in this setting that a knowledgeable interpreter is crucial, as it provides the opportunity to use and disperse the terminology and to educate the Spanish-speaking community.

Interestingly, two contrasting themes emerged. First, although it is unknown to what degree Latinas with pelvic floor disorders truly understand their conditions, at times office staff assumed that patients would be unable to understand. As stated by one member of the office staff, "That's why I said, they lack a little more understanding (than English-speaking patients)." On the contrary, some interpreters assumed that patients are already familiar with their anatomy and pelvic floor disorders. For example, one stated, "Some of them have been going through this for a long time, so they know what they have. They already know."

The use of interpreter services has proven to improve satisfaction with care, compliance, and outcomes in a primary care setting. However in our study, even when the clinician enlisted the help of a certified interpreter, there appears to be a significant and prominent gap in communication. Unfortunately, this calls into question how beneficial an interpreter service is in a sub-specialty setting, particularly in the realm of pelvic floor disorders. It appears that there is poor communication between the patient and the interpreter based on a weak level of knowledge of the medical conditions on the part of the patient and terminology. In order to ensure accurate and proper translation, efforts are needed to promote education at all levels of the workforce to improve our communication with the Spanish-speaking Latina population suffering from pelvic floor disorders.

Finally, system-related barriers were due mainly to a lack of access to informative tools in Spanish. A lack of Spanish paperwork posed a large barrier to communication. In our female urology clinics, it appeared that most of the patients were literate in Spanish, although this was not tested. In general, however, if a companion or family member was not present to help them, the office staff members often assisted with translation and completing questionnaires. It is unclear if incorrect medical history information was provided, and if it was due to a lack of understanding of their underlying comorbidities, their inability to understand the paperwork, or to write in English. Additionally, although terminology for pelvic floor disorders does exist in some dictionaries, in certain hospitals there does not appear to be easy access to it or it is not commonly used. As stated by one interpreter, "There's no way to get a real medical dictionary here. You would have to order it from Spain, and they don't give us the budget for that. So, we use whatever comes out of the Internet." There is, however, an abundance of literature available on the Internet. It is unclear if there is lack of access to the Internet or a poor understanding of how to use the Internet among underserved Latinas. Additionally, it is unclear if the Latinas lack a baseline level of understanding needed to interpret and retain the information they seek or are taught. Only after language barriers are broken can we better understand differences in beliefs and health behavior in between populations and the contribution of patient's level of education, socio-economic background, years in this country and their country of origin to their understanding.

To better define the problems addressed by this study, two questions emerge: First, what is the baseline knowledge of a Spanish-speaking woman about pelvic floor anatomy and

disorders? Second, how well are Spanish-speaking Latina patients able to understand their diagnoses, treatment options, and risks to therapies? Further studies are warranted to get a better understanding of these issues. Future double-blinded and randomized control trials in which communication and understanding between a control group and an experimental group will allow us to draw more concrete conclusions. Other areas of interest include the effects of literacy on disease understanding, and how geographic variations in Spanish affect communication based on regional differences within the United States as well as varying Latin American backgrounds of the patients.

Many levels of barriers to communications exist with Spanish-speaking women suffering from pelvic floor disorders at the level of the patient, interpreter, and within the system. There is a need to understand and optimize our communication techniques with the rapidly increasing Latina community within the United States to allow them the same access to care as English-speaking women. Additionally, there is a need to identify levels of health literacy in Latinas seeking treatment for pelvic floor disorders in order to develop a clinical environment that is conducive to effective communication. Our next step is to better define these barriers.

Acknowledgments

Funded by a National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) Patient-Oriented Research Career Development Award (1 K23 DK080227, JTA) and an American Recovery and Reinvestment Act (ARRA) Supplement (5K23DK080227, JTA)

REFERENCES

1. Nygaard I. Prevalence of symptomatic pelvic floor disorders in US women. *JAMA*. 2008; 300(11): 1311–6. [PubMed: 18799443]
2. Wu JMHA, Fulton RG, Myers ER. Forecasting the prevalence of pelvic floor disorders in U.S. Women: 2010–2050. *Obstet Gynecol*. 2009; 114:1278–1283. [PubMed: 19935030]
3. Whitcomb ELRG, Brown JS, Creasman JM, Thom DH, Van Den Eeden SK, Subak LL. Racial differences in pelvic organ prolapse. *Obstet Gynecol*. 2009; 114(6):1271–1277. [PubMed: 19935029]
4. Daneshgari F. Differences in urinary incontinence between Hispanic and non-Hispanic white women: a population-based study. *BJU Int*. 2008; 101(5):575–579. [PubMed: 18190644]
5. Percac-Lima SAL, Gamba GB, Bearse AM, Atlas SJ. Barriers to Follow-Up of an Abnormal Pap Smear in Latina Women Referred for Colposcopy. *J Gen Intern Med*. 2010 Jul 21. [Epub ahead of print].
6. Press RCO, Sciacca RR, Giardina EG. Racial/ethnic disparities in time to follow-up after an abnormal mammogram. *J Womens Health (Larchmt)*. 2008; 17(6):923–930. [PubMed: 18554094]
7. Marks R, Ok H, John Allegrante. Disparities in perceptions of healthcare provider communication among women: Findings from the 2003 Health Information Trends Survey (HINTS). *Global Journal of Medical Research*. 1(1):16–18. (n.d.).
8. Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine*. 1999; 14(7):409–417. doi:10.1046/j.1525-1497.1999.06198.x. [PubMed: 10417598]
9. Morales LS, Lara M, Kington RS, Valdez RO, Escarce JJ. Socioeconomic, cultural, and behavioral factors affecting Hispanic health outcomes. *Journal of Health Care for the Poor and Underserved*. 2002; 13(4):477–503. [PubMed: 12407964]
10. David RA, Rhee M. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *The Mount Sinai Journal of Medicine, New York*. 1998; 65(5-6):393–397.

11. Linsky A, McIntosh N, Cabral H, Kazis LE. Patient-Provider Language Concordance and Colorectal Cancer Screening. *Journal of General Internal Medicine*. 2010; 26(2):142–147. doi: 10.1007/s11606-010-1512-9. [PubMed: 20857340]
12. Traylor AH, Schmittiel JA, Uratsu CS, Mangione CM, Subramanian U. Adherence to Cardiovascular Disease Medications: Does Patient-Provider Race/Ethnicity and Language Concordance Matter? *Journal of General Internal Medicine*. 2010; 25(11):1172–1177. doi: 10.1007/s11606-010-1424-8. [PubMed: 20571929]
13. Charmaz K. 'Discovering' chronic illness: using grounded theory. *Soc Sci Med*. 1990; 30(11): 1161–1172. [PubMed: 2360052]
14. Charmaz, K. *Handbook of interview research: context & method*. Sage Publications; Thousand Oaks, Calif.: 2002. *Qualitative Interviewing and Grounded Theory Analysis*.
15. Eaves YD. A synthesis technique for grounded theory data analysis. *J Adv Nurs*. 2001; 35(5):654–663. [PubMed: 11529967]
16. Chesler, MA. Professionals' Views of the Dangers of Self-help Groups; Explicating a Grounded Theoretical Approach (Center for Research on Social Organization, Working Paper Series); Ann Arbor. 1987. Department of Sociology, University of Michigan
17. Boychuk Duchscher JE, Morgan D. Grounded theory: reflections on the emergence vs. forcing debate. *J Adv Nurs*. 2004; 48(6):605–612. [PubMed: 15548251]
18. John-Baptiste A, Naglie G, Tomlinson G, et al. The effect of English language proficiency on length of stay and in-hospital mortality. *J Gen Intern Med*. 2004; 19(3):221–8. [PubMed: 15009776]
19. Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos less satisfied with communication by health care providers? *J Gen Intern Med*. 1999; 14(7):409–17. [PubMed: 10417598]
20. Chen J, Fang H, Vargas-Bustamante A, Rizzo JA, Ortega AN. Latino disparities in prescription drug use and expenditures: a nationally representative analysis. *Ann Pharmacother*. 2010; 44(1): 57–69. [PubMed: 20118144]
21. Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *Int J Qual Health Care*. 2007; 19(2):60–7. [PubMed: 17277013]
22. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003; 111(1):6–14. [PubMed: 12509547]
23. Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services? *J Gen Intern Med*. 1997; 12(8):472–7. [PubMed: 9276652]
24. Baker DW, Hayes R, Fortier JP. Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Med Care*. 1998; 36(10):1461–70. [PubMed: 9794340]
25. Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K. Use and effectiveness of interpreters in an emergency department. *JAMA*. 1996; 275(10):783–8. [PubMed: 8598595]
26. Kale E, Syed HR. Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. *Patient Educ Couns*. 2010 Nov; 81(2):187–91. Epub 2010 Jun 9. [PubMed: 20542656]
27. Jacobs EA, Donald S, Shepard, Jose A, Suaya, Esta-Lee Stone MS. Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services. *Am J Pub Health*. 2004; 94(5): 866–869. [PubMed: 15117713]
28. US Institute of Medicine 2004 report. *Health Literacy: A Prescription to End Confusion* (Institute of Medicine, 2004).
29. Sudore RL, Landefeld CS, Pérez-Stable EJ, Bibbins-Domingo K, Williams BA, Schillinger D. Unraveling the relationship between literacy, language proficiency, and patient-physician communication. *Patient Educ Couns*. 2009; 75(3):398–402. [PubMed: 19442478]
30. Nutbeam D. The evolving concept of health literacy. *Social Science & Medicine*. 2008; 67:2072–2078. [PubMed: 18952344]
31. Baker DW. The meaning and measure of health literacy. *J Gen Int Med*. 2006; 22(1):878–883.

Figure 1. Barriers in communication and disease understanding among Spanish-speaking women with pelvic floor disorders:

PATIENT RELATED BARRIERS	QUOTES ABOUT PATIENTS
Overall lack of understanding of disease, anatomy, and medical history	<p>OFFICE STAFF: "I think because it's a specialty, a lot of them don't know exactly what it is, so I think if it's something outside of internal medicine, they really don't know what it is that they have."</p> <p>"They bring either the bottles of their medicines or the sample that you gave them. They don't know the name or why they were prescribed it."</p> <p>"As far as their anatomy, I don't think they're very schooled."</p> <p>"They know the symptoms they're having and they know their doctor told them to call us....I don't think when they spoke to their doctor that they had a translator or somebody that explained it to them."</p> <p>"A lot of patients we have to help them to fill out the forms because a lot of the medical history they don't understand. That's when we go sit down with them and go through their medical questions and answer them to help them."</p>
Inability to use medical terminology	<p>OFFICE STAFF: "In general, they don't know the anatomy and terminology of urological issues."</p> <p>"They tell everything in more detail. They say 'leaking, I drip, I go through pads.' English-speaking patients tell you only a little bit."</p>
Cultural restraints	<p>OFFICE STAFF: "They do (confide more to the translator) because they feel comfortable with me being a woman. I guess it's because of the way we grew up, it's very taboo to speak about our private parts."</p>
Embarrassment	<p>OFFICE STAFF: "They feel intimidated and I think again it's because of the language barrier."</p> <p>"I don't know if they're afraid to ask questions, or they don't understand and they are saying they do. Usually their answer is 'yes' to everything, even when they don't understand what's going on."</p>
Time consuming	<p>OFFICE STAFF: "I think they are most time consuming because you have to ask</p>

	<p>them more questions to get to the bottom of what they mean."</p> <p>"The questionnaires are not in Spanish so if they have difficulty in filling them out and if they don't bring someone with them, then they ask our staff. But then we're not always fully staffed...and therefore they don't have the help for them to fill out the questionnaires, which are not in Spanish..."</p> <p>"They say, 'My primary doctor is sending me to you guys.' Sometimes those are the most difficult ones because it takes a long time to figure out why there are here."</p>
Lack of questioning or involvement in plan	<p>OFFICE STAFF: "The patients that don't speak say 'yes' to everything that you tell them. And when I ask them, 'Do you understand?', they always say 'yes.' To me, I don't feel that they completely understand."</p>
PROVIDER RELATED BARRIERS	
Use of office staff as interpreters	<p>OFFICE STAFF: "We try to help them but then we're running back and forth and usually either of us is on the floor. We usually don't have time to sit because they take long. They take about anywhere to 35-45 minutes to fill out."</p>
Lack of knowledge of terminology	<p>OFFICE STAFF: "A lot of times we use Spanglish."</p> <p>"I went to school in Mexico. I know the old Spanish. But the dictionary Spanish, most of us don't know."</p> <p>(Is there a word for cystocele?) "No. See that's something I have to learn myself."</p> <p>"If they're going to come see a specialist, we need to know the definition of what they're describing."</p> <p>INTERPRETER: "I mean, usually those words (bladder, hysterectomy, uterus, rectum) I use all the time, but all the other ones, I'm going to be real honest with you, I haven't heard in all these years (cystocele, incontinence)."</p>
Poor understanding of diseases	<p>OFFICE STAFF: (Pessary) "Well isn't it ... I need more understanding myself, but is it a little thing that goes into you to control the urine?"</p> <p>"Stress incontinence? Isn't that when women leak urine when they are in a stressful situation in their lives?"</p>

Need to act as triage clinicians	OFFICE STAFF: "They are more complicated because all they know is that they're having some type of a pain or a problem and the doctor told them to call us. They tell their symptoms and I figure it out by looking in the system. They don't really know what they're calling in for... Then once I look up their information, I make sure that's what they're coming in for so I try to provide as much information on the chief complaint as I can."
Assume lack of knowledge	OFFICE STAFF: "That's why I said, they lack a little more understanding." "They don't know. They don't have any clue what it says." "I don't know if they're maybe not told, or they don't really understand what they're (referred for)."
Assumption of good knowledge	INTERPRETER: "Pesario? I'm pretty sure that the patient is probably going to know it. I don't really ... that is not really my area." "Some of them have been going through this for a long time, so they know what they have. They already know. They are going to know these words."
SYSTEM RELATED BARRIERS	
Lack of information tools	OFFICE STAFF: "Some of them don't have computers or they don't know how to use them."
Lack of Spanish forms	OFFICE STAFF: "Sometimes when I see their paperwork, a lot of times they only fill out the name, address, date-of birth and where they were born. They don't even know how to fill out the rest." "Some ask for help so we go and help with the paperwork ... When it comes down to questionnaires, we have the past medical history, and they don't even know what to check off. A lot of the time they don't know when they see it in English ... A lot of times the past medical history is too hard because they don't know how to read it." It makes it difficult for us because we do need their medical history...I mean, they try to fill it out but the patients that don't understand cross everything off, that they have everything wrong." "They would know how to write it in Spanish because I've seen it done, but they can't translate it into English."

Lack of vocabulary	OFFICE STAFF: "I think if they knew there's an exact word to describe it, they would probably use it more...they just describe a lot. They don't have an exact word in the vocabulary." INTERPRETER: "There's no way to get a real medical dictionary here. You'd have to order it from Spain, and they don't give you the budget for that. So, whatever comes out of the Internet."
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Figure 2.
Preliminary Themes and Representative Quotes

Figure 3.

Routes of communication with an English-speaking patient are usually directly by the provider or by various informational tools. In comparison, Spanish-speaking patients do not have a direct form of communication, and instead require additional parties or steps in order to receive the same information. Ideally, this is provided by either the use of a certified interpreter or by translated forms, however it is quite common to utilize the aid of a non-certified bilingual interpreter in the form of a family member, office staff member, nurse, or other personnel in the medical center. Each of these additional steps serves as a potential barrier to optimal communication with Spanish-speaking patients.