Published in final edited form as:

OTJR (Thorofare N J). 2015 April ; 35(2): 120–128. doi:10.1177/1539449215575265.

Language Discordance and Patient-Centered Care in Occupational Therapy: A Case Study

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Abstract

The accumulative burden of a growing non-English speaking minority population and health disparities in the United States demonstrate the urgency of examining occupational therapy practices and defining care that is timely, effective, safe, and patient-centered. In this context, we investigate an occupational therapy episode of care from the perspectives of patient, caregiver, and primary occupational therapy care provider. Treatment sessions were observed and one-on-one semi-structured interviews were conducted with the participants. Several themes describing areas of concern in communication and care delivery emerged, including expectations for care, the therapy relationship, professional identity, and pragmatic constraints. The use of untrained interpreters compromised treatment effectiveness and safety. This case highlights potential areas of concern in therapy when working with a diverse patient population. Abundant opportunities exist for occupational therapy to situate itself as an equitable, responsive, valuable, and essential service.

Introduction

Health disparities permeate the U.S. health care system, disproportionately affecting minorities and posing an increased burden to the U.S. economy. Premature death, lower worker productivity, and an increased likelihood of rehospitalization not only represent a loss of human potential and productivity, but also contribute significantly to the economic impact of health disparities (LaVeist, Gaskin, & Richard, 2009; McHugh, Brooks Carthon, & Kang, 2010). Specifically, an estimated annual loss of \$309 million dollars is attributed to the direct and indirect costs of health disparities (Kaiser Family Foundation, 2012).

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The authors have no financial or proprietary interest in the materials presented herein

Health disparities in health care quality, access, utilization, and outcomes persist even after factors such as socioeconomic status, geographic location, age, gender, and length of time in the U.S. are taken into account (Institute of Medicine [IOM], 2003; Kaiser Family Foundation, 2012). The field of rehabilitation is not exempt, as research has documented disparities among minority post-acute care populations including a lower volume of rehabilitative care for, decreased receipt of intensive rehabilitation care for, and decreased functional status ratings at discharge (Cary, Merwin, Oliver, & Williams, 2014; Freburger, Holmes, & Ku, 2012; Meagher, Beadles, Doorey, & Charles, 2014; Ottenbacher et al., 2012). The pervasive nature of health disparities are of particular concern, given population projections estimating that minority populations will become a numerical majority of the total U.S. population by 2043 and will compose 57% of the population in 2060 (U.S. Census Bureau, 2012). In light of the changing U.S. demographics, reports of disparate care, and poor health care outcomes, it is imperative that the profession of occupational therapy examine its own practices and define high quality care that is timely, effective, and patient-centered.

Patient-centered care is compassionate, respectful, and responsive to patient preferences, needs, characteristics, and values (IOM, 2001). This approach revolves around the collaboration between the provider, patient, and support network, emphasizing the patient's role as an active, informed participant in decision-making. It follows that effective communication is an essential component of patient-centered care that is safe, equitable, and of high-quality. The patient must be able understand his or her diagnosis and the importance of clinical services, prevention, and timely treatment. Alternatively, clinicians must understand individual preferences and expectations to determine how the patient will receive, interpret, and share health information (Beach, Saha, & Cooper, 2006). Good communication strengthens trust and the therapy relationship, facilitating patient engagement in shared decision-making, a key component of patient-centered care (Elwyn et al., 2012; Taylor & Jones, 2014).

Health care outcomes are directly impacted by the dynamic relationship between system characteristics, patient characteristics, and the intervention (Mitchell, Ferketich, & Jennings, 1998). Barriers to high quality care are present each of these levels. Presently, providers and organizations face special challenges in accommodating the approximately 59.5 million people that speak a language other than English at home (U.S. Census Bureau, 2013). Current policies, increased costs, a lack of trained interpreters, decreased institutional support, and limited availability of high-quality, evidence-based training programs for clinicians challenge care to diverse populations at the system level (Balcazar, Suarez-Balcazar, Taylor-Ritzler, & Keys, 2009; Jacobs, Shepard, Suaya, & Stone, 2004; Like, 2011; Parés-Avila, Sobralske, & Katz, 2011; Suarez-Balcazar, 2011). Patient values, preferences, skills, cultural identity, and practitioner assumptions influence the care encounter at the patient level (AOTA, 2014; Bonder, Martin, & Miracle, 2004). Interventions that do not meet patient needs and preferences have also been linked to decreased quality of care, satisfaction, and clinical outcomes (Parés-Avila, Sobralske, & Katz, 2011). Consequently, a thorough understanding of the multiple factors at play in a clinical encounter is essential to providing patient-centered care.

Occupational therapy practitioners support health, well-being, and occupational engagement through a focus on the transactional relationships between patient-specific factors, contexts, and environments. Occupational therapy practitioners recognize the dynamic interactions of these components and respond by utilizing a holistic approach in clinical care (American Occupational Therapy Association [AOTA], 2014). To this end, occupational therapy practitioners are well positioned to deliver person-centered care to support occupational engagement by taking into account an individual's patient preferences, needs, characteristics, and values.

Occupational therapy research has investigated the relationship between culture and occupation, as well as methods for bolstering practitioner's skillsets (Muñoz, 2007; Stedman & Thomas, 2011; Suarez-Balcazar et al., 2009). Supporting faculty and fieldwork educators in bridging academic and clinical settings to best support practitioners caring for diverse populations has been identified as an important contributor to professional development (Donoso Brown, Muñoz, & Powell, 2011; Humbert, Burket, Deveney, & Kennedy, 2012; Toal-Sullivan, 2006; Trentham, Cockburn, Cameron, & Iwama, 2007; Tryssenaar & Perkins, 2001).

Alarming, although occupational therapy practitioners recognize working across cultures as an essential skill for practice, many are not confident in the efficacy of their interventions (Cheung, Shah, & Muncer, 2002; Stedman & Thomas, 2011; Suarez-Balcazar et al., 2009). To the best of our knowledge, no studies to date have explored the perceptions of the patient-provider-caregiver triad in a clinical encounter in the context of patient-centered care. More noticeably, the patient's voice is often absent from occupational therapy literature and needs to be investigated.

Our study seeks to capture patient, provider, and caregiver perspectives in the discussion of high quality, patient-centered care to diverse populations within occupational therapy. Our aims are to: (a) explore the perceptions of the patient-provider-caregiver triad in the context of patient-centered care, with an emphasis on that of the patient; (b) identify facilitators and barriers to patient-centered care with a diverse patient population; (c) identify potential solutions and directions for future research. The case study will focus on: (a) a Mexican, Spanish monolingual patient; (b) the patient's Mexican, Spanish monolingual wife; (c) an American, English monolingual Level II Fieldwork student assigned to this case; (d) the student's fieldwork educator. Participant interviews and therapy session observations will guide the development of common themes. Based on the themes that arise we will delineate recommendations for occupational therapy practice.

Methods

Design

This study utilized the descriptive case study model and methodology to describe and analyze real life situations in their natural context (Yin, 2008). A single case study design was chosen to develop an in-depth description of the phenomenon being investigated.

Participant Selection

A patient, his wife, the Level II Fieldwork student assigned to this case, and the student's fieldwork educator participated voluntarily in data collection for this study. Purposive sampling was utilized to identify patients who: (a) were scheduled for weekly outpatient occupational therapy appointments; (b) consistently attended scheduled therapy appointments; (c) were regularly accompanied by a family member or caregiver to occupational therapy appointments; (d) were Spanish monolingual; (e) self-identified as Hispanic/Latino. Six patients were identified through practitioner referrals as potential participants and were approached in person for the purpose of identifying one patient and caregiver dyad willing to participate in this study. Practitioners assigned to potentially eligible patients were approached only after patient and caregiver informed consent was secured. Two patients and their caregivers met the inclusion criteria. After then approaching these patient's practitioners for consent, only one patient-provider-caregiver triad was willing to participate in this study. Study interviews and observations began once consent was obtained from all participants. These procedures were performed by a bilingual occupational therapy researcher who is also a native Spanish speaker (first author blinded for review).

Data Collection

Data collection included semi-structured interviews, clinical observations, and field notes. Interviews with each of the four participants (e.g. patient, family member, fieldwork student) occurred at weeks one, three, and six of the six-week study period as shown in Table 1. The student's fieldwork educator was interviewed once at week five. Each interview was approximately 45 minutes long and occurred after the patient's occupational therapy session. Interviews were conducted in the language of the participant's choosing (English or Spanish), audio recorded, and transcribed. Personalized interview guides were developed for each of the participants to ensure all relevant topics and subtopics related to individual roles in care were considered. Interview guides were reviewed by three other occupational therapists. Interview discussion topics included occupational therapy treatment experiences, concerns about care, expectations for future therapy sessions, and perceived barriers and facilitators to care.

Data triangulation included unstructured observations of each treatment session and the development of field notes immediately after each observation during the six-week study period (Mulhall, 2003; Thurmond, 2001). The patient in this case received occupational therapy services in a group format, meeting twice weekly for one hour and thirty minute sessions. Sessions were led by two occupational therapists and one Level II Fieldwork student. However, only the fieldwork student and her fieldwork educator were interviewed due to their role as the patient's primary providers.

Data Analysis

Data included observation notes for twelve clinical sessions, ten audio recorded interviews, and field notes for each observation and interview session. All audio recorded interviews were transcribed verbatim by the bilingual occupational therapy researcher in the language that the interview was conducted (English or Spanish). A data-driven, recursive analysis was

conducted at both individual and group levels. Participant transcripts were initially analyzed independently of each other to capture the essence of each participant's perspective. Transcripts were subsequently analyzed as a group for common themes.

Specifically, transcripts were read for familiarization and actively reviewed for potential patterns or issues of interest. Initial codes were developed using a qualitative analysis software program (Atlas.ti), analyzed, and grouped into potential themes and subthemes. Candidate themes emerging across all participant interviews were developed, reviewed, and compared to selected quotes and the entirety of coded data. Finally, themes were compared to observation and field notes for verification (Braun & Clarke, 2006). Preliminary interpretations were presented to the patient and caregiver in a member checking session to ensure the validity and credibility of the interpretation of the data. The resulting findings are situated in the context of patient-centered practice in a diverse patient population.

Description of the Participants

Four participants participated in this study. Pseudonyms have been used to maintain anonymity.

The Patient

José is a 48-year-old, Mexican, Spanish monolingual male. He is the owner of a clothing shop in a small city in southern Mexico who frequently visited the U.S. to obtain apparel to sell in his shop. At the time of this study, José was receiving outpatient occupational therapy services for a spinal cord injury resulting from a motor vehicle accident during his last trip to the United States. José and his immediate family relocated to the U.S. permanently following his injury. Clinically, José experienced a fracture dislocation of the C5-6 vertebrae and now demonstrates a tendonesis grasp with limited strength in the shoulders and elbows.

The Patient's Wife

Olivia is a 44-year-old, Mexican, Spanish monolingual female. She is José's wife of 20 years and mother to their three children (ages 14, 18, and 20). Prior to José's accident, Olivia managed the couple's shop in Mexico. Olivia now lives in the U.S. and is José's sole caregiver.

The Occupational Therapy Fieldwork Student

Lauren is a 25-year-old, American, English monolingual female who spent the majority of her life in a New England suburb. She pursued occupational therapy after working as a massage therapist for several years and attended an occupational therapy school near her hometown. Lauren was completing her second Level II Fieldwork affiliation at the time of our study. She moved away from home to pursue a clinical experience in a large and diverse city in California with a large Hispanic/Latino population.

The Student's Fieldwork Educator

Jill is an occupational therapist with over twenty years of experience as an occupational therapist and as a fieldwork educator. She has worked extensively with diverse patient

populations through her clinical practice and has supervised many Level I and Level II Fieldwork students.

The Care Facility

The facility is located in one of most populous cities of the U.S. and serves a large indigent population. Over half of the patients seen by this facility are Hispanic or Latino, low-income, immigrants, and monolingual Spanish speakers. The facility provides acute care, inpatient rehabilitation, and outpatient services.

Findings

Four themes and one subtheme emerged through a data-driven thematic analysis and are discussed in detail below. The theme of *expectations for care* describes perceptions of occupational therapy services and goal-setting within a rehabilitation context. The theme of *the therapy relationship* describes the development and effectiveness of relationships within the patient-provider-caregiver triad. The theme of *professional identity* discusses challenges to professional identity faced by the primary care provider. Finally, the theme of *pragmatic constraints* discusses the role of real life contexts on the delivery of care and is divided into the respective subthemes of *personal factors* and *organizational factors*.

Expectations for Care

This theme relates to the difficulties encountered when setting treatment goals and establishing occupational therapy as a key component of medical care. All participants expressed frustration caused by the negative impact of language discordance on occupational therapy services. Language discordance occurs when the patient and care provider lack proficiency in the same language (Sears, Khan, Ardern, & Tamim, 2013).

José recalled discussing the importance of occupational therapy services with his therapists but could not recount why occupational therapy was important to his care. During treatment, José was observed to have difficulty identifying meaningful occupations and often selected to work on novel activities during occupational therapy sessions. For example, he chose to paint during one session even after stating that it was not something he was interested in. When asked describe how he chose what he wanted to work on during each occupational therapy session, José explained that the purpose of occupational therapy treatment activities was to help him stave off depression while he regained the ability to walk. He says:

[Therapy's goals] are that I become self-sufficient. If I'm not going to walk to at least not depend so much on my family. I think that's the goal. As for me, well, I would like to walk. My goal is walking. My goal is to be able to fend for myself and not depend on my wheelchair. My goal, is like I'm telling you, to do things that make, make, that make my legs respond. But in the therapy session they can't give me just that. Instead, I do things that keep me busy so I don't get depressed.

Language discordance made it difficult for Lauren to articulate her clinical reasoning, educate José about occupational therapy, jointly establish treatment priorities, and monitor

José's adjustment to life with a spinal cord injury. Lauren expresses about the goal setting process:

And also, um, just finding out like, exactly what they want to achieve... and sometimes I understand that patients sometimes aren't really sure, they just want to in general get more function. But you know, he might have some specific goals that he really wants to work on, but like, it is just getting lost in translation.

Language discordance and adjusting to the role of a caregiver left Olivia with many questions about José's care. Unable to communicate with Lauren, she looked to other patients and their families for support and answers. These connections helped her realize that "this is not going to be for a short time, it is going to be for a long time", a realization that dispelled her belief that José would make a full recovery while in the hospital. She says, "I believed that they [medical professionals] were just going to hand him over to me and he was going to be well. It's like your mind does not, not get the severity of the situation. Now it's permanent."

The Therapy Relationship

This theme relates to the issues impacting the development of an effective therapy relationship. Language discordance impeded Lauren and José from building a strong relationship, setting meaningful goals, and mutual decision-making.

Language discordance between Lauren and José limited their interactions. Lauren's confidence as a practitioner suffered and she did not engage José as an active participant in his care. Lauren could not ensure that José comprehended her instruction, did not have any questions, or that he truly agreed with all decisions. She says about communication with José:

It's just, it's usually like, little quick comments. We've never really have a full on conversation about anything. It's a lot of gestures and pointing and keeping the conversation very light. You know, a silly little joke and we'll both chuckle, but that is like, that's the extent of it. I wish we could have longer conversations. I'm trying to read his language and his facial expressions and his level of interest or how much he responds to a suggestion. Like does he actually understand what we are talking about or is it like a "Meh, probably" kind of deal. Like where he just shrugs it off because he does that a lot. So it is hard to know if he's just agreeing with something or is not interested.

José and Olivia described experience and confidence as the most important characteristics of a trustworthy clinician. Although Lauren was still developing both skill and experience, José and Olivia chose to place their trust in her because of their confidence in Jill's clinical and supervisory experience. José and Olivia described feeling at ease with Lauren due to her "heartfelt willingness to help and to be of service". Olivia says of Lauren, "She is very sweet and she has the desire to help. You can see the love, you can see her happiness, her openness." Lauren says of her connection with José and Olivia, "I really like them and I feel like they like me for trying and for being there. Understanding one another is not necessary, it's not language-based."

Professional Identity

This theme relates to the challenges to professional identity faced by the primary occupational therapy care provider. Practitioner professional identity and confidence were negatively impacted.

Lauren was frustrated by her relationships with her Spanish monolingual patients, questioned her effectiveness as a practitioner, and was wary of offending her patients. Her frustrations persisted throughout all of her interviews. She describes:

It kind of feels like, you know it's probably boring for them to just have me there, standing there. So I tried to, like, do something with them. And then also it's like "oh God please don't ask me a question that I can't answer" or "how stupid am I" or "how frustrated are you going to be if I am trying to say something to you and I am clearly not making sense". So a lot of it is insecurity and even when I do use Spanish to communicate, I get wicked insecure because I do not want to insult them by speaking really broken Spanish or saying something completely incorrect and them being like while you're not very smart after all... And that just frustrates me because I don't want to look like an idiot and I don't want waste their time by me not being able to communicate.

In her interview, Jill described her personal approach to working with patients from diverse backgrounds as an expert occupational therapist. Her approach is the same for each patient, no matter what culture the patient identifies with or what language the patient speaks. Jill relies on her sharp intuition and observational skills to adjust her approach with each person and to gauge patient understanding. She works with interpreters during most of her sessions because she believes that "You've got to get someone there if you really feel like you are losing something or not getting something." Jill also sees respect and showing patients that she "hears what their concerns are" as facilitators to forming genuine interpersonal connections. While Jill factors a patient's cultural identity in the clinical reasoning process, she is mindful of not making assumptions about her patients. She ensures that she discerns what is important to her patient through open dialogue and questioning, crediting being "client-centered instead of culture-centric" with helping her bridge remaining cultural gaps. As a fieldwork educator, Jill aims to develop student critical reasoning and facilitate their ability to adapt their therapeutic approach as needed, further facilitating caring for diverse patient populations.

Pragmatic Constraints

This theme relates to real life barriers to the delivery of patient-centered care to a diverse patient population. It is subdivided into real life difficulties related to personal factors and organizational factors.

Personal factors—Ineffective communication strategies, especially when working with interpreters, and reliance on observation and nonverbal communication negatively impacted treatment, goal development, and safety. In this case, Lauren was unfamiliar with interpreters and their value in a clinical encounter. She routinely questioned her interactions with them, and wondered what content could be interpreted, where to look, who to speak to,

when to pause, and where to stand or sit. This complicated her interactions with José, affected what information she ultimately conveyed to her patient, and led to a decision to not work with an interpreter for a few sessions. She describes:

As I started to, you know, have a more personal relationship I realized that I really didn't like that third person. I thought that it was really awkward because you want to talk to the patient, but at the same time you have to make sure that the interpreter is hearing you, so. Who you look at is awkward and you know, I hate those- you say it to the interpreter and the interpreter processes it and repeats it back- those awkward pauses in between where everyone is just kind of looking at each other. So, it is bittersweet.

José's basic English skills and reliance on nonverbal communication may have led various care providers to falsely assess his understanding of all discussions, further affecting treatment and safety. In his interviews, José expressed frustration due to communication difficulties and that he only understood some of what been said at his appointments. José described asking for assistance as a sign of weakness and noncompliance. José wanted to be strong, composed, and to fulfill his "duty as a good patient to do what is asked of me", a sentiment that his care providers were unaware of. He describes: "If there is someone near me to interpret, then good, but if not, I will keep my questions and doubts to myself."

Organizational factors—Patient safety and overall treatment fidelity was affected by Lauren's perception of a lack of institutional support and availability of language access services. Lauren initially expressed not accessing the services available to her because she did know they existed. Once Jill, her supervisor, became aware of this and introduced her to the services available, Lauren tried to incorporate interpreters in her sessions but was disheartened by the process. Completing interpreter request forms days in advance and a high probability that interpreters would be unavailable made accessing language access services frustrating. The facility's few interpreters worked throughout the entirety of the hospital, struggling to meet the high demand for services in both inpatient and outpatient areas. The resulting likelihood that an interpreter would be behind schedule or unable to attend reinforced her decision to rely on ad hoc interpreters or her own basic language skills to communicate. When an interpreter was present, a lack of exposure to working with interpreters in academia and clinical practice induced more stress. She says:

I don't think that there are enough supports available. It was more of me figuring it out on my own for sure. I don't know if that's like, true of everywhere, but that's how it felt for me. It was just initially, like, "who do I call" or "who do I need", or like, "what if the interpreter doesn't show up", or like... I just felt like, I just felt like I always didn't know who to go to if I had a question about something.

The employment of ad hoc and untrained interpreters also impacted ethics and patient safety significantly. In his interviews, José initially expressed a preference for ad hoc interpreters and that the resulting lack of privacy was not a concern. Upon further probing, he recounted the distress he felt when his teenage daughter served as an ad hoc interpreter for a group on sexuality after spinal cord injury. He says, "There was a talk here about sexuality and my daughter was the one that was translating. Then in that moment I wish that I could

understand and I was very embarrassed. My daughter was translating to me and was even translating to those who were next to me, including another young man.”

José became dizzy during a research-observed treatment session. Both Lauren and Jill missed the signs of José’s distress and did not understand his request for assistance. Fortunately, another patient and his father recognized that something was wrong and alerted Lauren. When asked about the incident during the subsequent interview, she described:

Um... especially today, I thought that José was trying to tell me that his eyes were bothering him and I was like... I was trying to figure out if they were dry or if there was too much light, and then [other group member’s] dad was yelling like, “Oh, he’s dizzy, he is saying that he is dizzy!”. And I am like “Ahh! God, I had no idea”, and that is a pretty big deal for someone with a spinal cord injury because it could be, like, I don’t know, like dysreflexia!

Over time, José and Olivia became more actively involved in sessions that incorporated an interpreter. More information was exchanged, yet the situation was still far from ideal. The interpreter assigned to José was a past patient of the facility who returned as a volunteer. Although he attended a volunteer training, he had not received formal training in interpreting or been assessed for fluency. The interpreter was observed to make regular interpretation errors, omit and modify messages, and frequently answer José’s questions himself during multiple researcher-observed treatment sessions. José and the interpreter were also observed to share dialogue that further reflected the interpreter’s personal agenda and clinical recommendations based on his own experience as a patient. For example, the interpreter recommended various folk remedies, exercises he observed others perform in the clinic, and exercises from his own home program. Although the interpreter made such recommendations with the intention of helping José, he appeared to be unaware of the potential danger of his actions, the effect on his actions on José care, the ethical implications of interpretation, or of clinical roles and boundaries. Lauren and Jill were not aware of these transactions as they occurred in Spanish.

Discussion

Our study’s investigation into the perspectives of the patient-provider-caregiver triad provides insight into delivering patient-centered care in the presence of communication difficulties. Although this study sought to investigate the perceptions of the patient-provider-caregiver triad in the context of patient-centered care, difficulties in communication caused by language discordance quickly emerged as the primary barrier to patient-centered care. Past research has also linked communication difficulties and language discordance between patient and clinician to decreased quality of care (Flores, 2014; Jimenez, Moreno, Leng, Buchwald, & Morales, 2012; Mohammed et al., 2014). Consequently, challenges to communication will serve as the focus of this discussion.

Communication-based challenges to high quality care arose even despite facility efforts to respond to the unique needs of their Spanish monolingual patient population. Consistent with previous findings, barriers to patient-centered care were evident at the system, patient, and intervention levels (IOM, 2003; Mitchell, Ferketich, and Jennings, 1998). Exposure to

Although Jill was a seasoned clinician, she also expressed difficulty teaching Lauren effective strategies for dealing with a language discordance. In her supervisory role, she cited limited access to formal training or support regarding training students in patient-centered care with diverse patient populations as barriers to meeting student needs. Jill described her self-taught approach as one that relied on getting to know the patient and his or her personal preferences (“client-centric”) instead of as a member of a cultural group (“culture-centric”). However, she was unsure how to best help Lauren develop these skills. Research suggests that students do not feel adequately trained in skills for working with diverse patient populations by their academic programs and instead rely on fieldwork sites to acquire these skills (Chiang & Carlson, 2003; Murden et al., 2008). This underscores the importance of ensuring that fieldwork educators are equipped to facilitate learning in this area, are up to date with best practices, and feel supported by their peers. Strategies to improve quality of care such as enhancing patient-provider communication skills, practitioner self-reflection, practitioner examination of implicit biases and assumptions, and continuing education offerings have been suggested as ways to support caring for diverse patient populations and support future efforts targeting students as well as clinicians (Bonder, Martin, & Miracle, 2004; Muñoz, 2007; Murden et al., 2008; Stedman & Thomas, 2011; Thompson, Hernandez, Cowden, Sisson, & Moon, 2013; Suarez-Balcazar et al., 2009).

Generalizability of results is limited by our study’s purposeful sampling of one patient-provider-caregiver triad from a single clinical setting, enrollment of a patient-caregiver dyad that self-identified as Hispanic/Latino, and six week study period. While our study also investigated the perspective of a seasoned clinician, this viewpoint was captured in an effort to illustrate the role of the fieldwork supervisor. Thus, an investigation of the effectiveness of her approach to working with diverse patient populations was beyond the scope of our study. The continued investigation of the perspectives of patient-provider-caregiver triads from evaluation to discharge, students, and seasoned clinicians, would enhance our understanding of providing patient-centered care to diverse patient populations. Specifically, the perspectives and health care experiences of racialized communities are important topics for future research. Further investigation into the role of communication difficulties in care, ways to best support students and seasoned clinicians, and investigation into interpreter perspectives are also promising areas of future investigation.

Our investigation into the perspectives of the patient-provider-caregiver triad and the delivery of patient-centered care in the presence of communication difficulties has shed light on issues that can arise at the level of the system, patient, and intervention. Insight into participant perspectives has been achieved through: (a) analysis of the therapy relationship from various perspectives; (b) identification of facilitators and barriers to care in the presence of language discordance; (c) identification of potential solutions and directions for future investigation.

Communication in the presence of language discordance is only one factor to consider in the delivery of patient-centered care to diverse patient populations and in the complex interactions within patient-provider-caregiver triads. Abundant opportunities exist for researchers, therapists, and students to strengthen occupational therapy’s commitment and

responsiveness to diverse patient populations and advance occupational therapy's progress toward attaining its Centennial Vision (AOTA, 2007) by: (a) expanding the field's body of knowledge regarding providing patient-centered care to diverse patient populations; (b) incorporating all stakeholder perspectives in clinical decision-making and research; (c) investigating best practices for supporting students and clinicians in the delivery of patient-centered care. The profession's response to this call will ensure that patients from all walks of life receive high quality, equitable, patient-centered care, and that occupational therapy situates itself as a valuable and essential service.

Acknowledgments

Natalie Leland was funded by the National Center for Medical Rehabilitation Research in the Eunice Kennedy Shriver National Institute of Child Health and Human Development and the National Institute of Neurological Disorders and Stroke (Grant No. K12 HD055929).

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Table 1

Semi-Structured Interview Schedule for Case Study Participants

Participant	Study Period					
	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Patient	Interview		Interview			Interview
Caregiver (Wife)	Interview		Interview			Interview
Level II Fieldwork Student	Interview		Interview			Interview
Occupational Therapist					Interview	