¿No Hablas Ingles?
Culturally Relevant Health Care for Children of Hispanic Families

HONRS 499

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When thinking of culturally competent care, one individual that comes to mind is Mother Teresa. An Albanian from Macedonia, Mother Teresa bridged all cultural gaps and provided love and care to the people of India (Frangsmyr, 1979). Through her love, she proved that she understood culturally competent care. She said, “We think sometimes that poverty is only being hungry, naked and homeless. The poverty of being unwanted, unloved and uncared for is the greatest poverty. We must start in our own homes to remedy this kind of poverty” (Lusk, 2005). Currently in the United States of America, there is a population that is feeling the effects of this second kind of poverty. This population is the Latino population.

The Latino population comprised 5.4% of the American population in 1980. This number increased to 15% in 2009 and is predicted to be 30% by 2050. As the most rapidly growing minority in the United States, currently the Latino population makes up 45 million people. Over half of the Hispanic population is first generation immigrants and the median age is twenty-eight years old (Vega, 2009). This dynamic presents health care providers with the opportunity to refine their culturally competent care by understanding and providing for this rapidly growing group of individuals. By understanding the cultural expectations and backgrounds of this population, studying the socioeconomic barriers, and looking at the current health disparities, health care providers can directly address health care for the Hispanic population.

Cultural expectations of the Hispanic population have a direct impact on their perception of their health care. These differences include the concept of time and their expectations of the physician. Other differences include family member responsibility, the pursuit of preventative care, emphasis on family support, and lifestyle choices. Socioeconomic differences that influence Hispanic health care in the pediatric setting include income, insurance, mother’s education level,
and the concept of a medical home. Lastly, the language barrier is the most obvious barrier to providing care to the Latino population.

The Hispanic concept of time is very different than that of most Americans and seems to be one of the biggest influences on their perception of their health care. The National Survey of Children’s Health conducted a survey of 91,642 phone interviews from April 2007 through July 2008. While compiling results, the researchers divided the Latinos based on the language they used for the interview. The three groups were Latino with Spanish Language Interview (SLI), Latino with English Language Interview (ELI), and Non-Latino White. They discovered that only 54% of the SLI population (n=3,959) felt that the provider spent enough time with them. This was compared to 77% of the ELI population (6,772) and 89% of the non-Latino white population (n=59,170). The article revealed that in all actuality the physicians feel that they spend more time with their Spanish-speaking clients than their English speaking clients (DeCamp et al, 2011, p. 1160). These results disclose two realizations: one, the physicians are not opposed to spending more time with their Hispanic clients and two, these Latino clients feel that they are still not getting enough time, lending one to believe that the issue is cultural differences! Interestingly enough, 81% of the same SLI population responded that their provider listened carefully to them. This is compared to 86% of the ELI and 94% of the Non-Latino White population (DeCamp et al, 2011, p. 1160). This Latino population did not associate listening carefully to spending enough time with them. Again, this is a difference of cultural perception. Recognizing this allows the physicians to be intentional about the time they spend with their Latino clients. They can recognize that half of the Latino clients are first generation immigrants, meaning they bring their perceptions and expectations of health care with them from their
countries of origin. Many of their hometowns are smaller, so the doctor can afford to spend much more time with them.

In the Hispanic culture, spending time with someone acknowledges his or her value, showing love and respect. As an employee of a restaurant for six years, I have developed many close friendships with other staff members. One of them is a busser named Luis. He is a first generation immigrant from Mexico and moved to the United States when he was in his fifties. He speaks very little English, so he and I developed a close relationship because of my fluency in Spanish. One day, I came into work on an exceptionally busy evening. Louis said hello to me and I quickly returned his greeting as I rushed past him to serve the guests. Thinking nothing of it, I planned on talking to him later in the evening. As the night came to a close, he asked me what he did to upset me. Puzzled, I told him I did not understand. He said that I had ignored a good friend in order to take care of a customer and that friends do not do that to each other. I quickly realized this was an issue of cultural difference. My priority was to serve the guests at the restaurant first and take time to talk with friends later, but Louis’s was to check in on those he loved and provide for the guests after he had done so. This story demonstrates a component of the Hispanic population’s frustration with American health care. Many Latinos would rather have the doctor be running late and wait longer for an appointment if it means they may spend as much time as desired developing a relationship with the doctor and staff. Meanwhile, most Americans value efficiency over relationship. This dynamic creates dissatisfaction among Latinos that must be addressed and explained by the medical staff.

As a result of this dynamic, many members of the Hispanic population express feeling dissatisfied with the relationship they have with their doctors and nurses. In a study exploring
Mexican American Mother’s expectations of health care for their children, the researchers discovered through focus groups that a “good doctor” is one who introduces himself when entering the room, knows the child’s name already, and remembers the child’s health history when meeting with the child. While it is impossible for a physician to remember each of his client’s names and health histories, knowing these results should help train the physician to review the client’s chart prior to entering the room. This small change will make a big difference in the client’s satisfaction with their care in the Hispanic culture. Another aspect that drastically affects the Hispanic perception of health care is the idea of getting what you pay for. During an interview, one woman said (translated from Spanish) “All they did was look at his throat; they didn’t even give him any pills, nothing. They treated him like an animal, like a cockroach” (Clark et al., 2011). While many Americans understand that some things just do not have a cure (like a sore throat) and just accept that there is nothing the doctor can do, this woman was dissatisfied. Why, because she comes from a culture where the physicians treat the symptoms as well as the cause. She was expecting the doctor to empathize with her son and give him something to help make his throat feel better even if there was no cure for his ailment. She comes from a culture that believes in herbal remedies and alternative medicine. Even though she was not treated poorly, based on what she disclosed she still felt like she was.

The next thing to consider when addressing the Latino population is assessing who makes the decisions in the family. It has been determined that the women are the ones that are engaged in the lives of their children and are the ones responsible for detecting potential health concerns. It is also true, however, that the mother must obtain permission from the father in order to act on her observations. Watts, Cowden, Cupertino, Dowd, and Kennedy conducted a research study on Spanish-speaking parent’s perspectives on 911. They encountered this family dynamic when
doing their research. They went to a Hispanic woman’s home for an interview, and upon arriving they discovered that one of the women’s children had gotten very ill that day. The interviewers asked her why she had not taken the child to the emergency room (ER) or quick clinic, thinking that they could give her a ride if she needed one. Her answer was not what they expected. She told them that she would rather delay health care for her child and receive her husband’s permission when he got home from work, than act without his knowledge. The researchers concluded that:

Neither the additional cost of an emergency department visit nor the lack of a primary care relationship in that setting appeared to be her primary concern. More compelling was the need for her husband’s approval for the visit and his support at the clinic (Watts, 2011).

Another relevant issue pertaining to the health care of the Hispanic client is understanding his or her view on preventative care. Two realities make this a big issue. First, many of the most common causes of death in the Latino population are causes that could be prevented or treated with screening and immunizations. Secondly, due to lower incomes and decreased prevalence of insurance, the Hispanic population does not see the practicality of pursuing preventative care. It is vital for health care providers to stress the importance of preventative care because so many causes of death for the Hispanic population in the United States are due to preventable causes.

Familismo is another important concept for the medical professionals to understand about the Hispanic population. In a study entitled “Mexican Immigrant Mothers’ Expectations for Children’s Health Services” researchers Clark and Redman discovered that the immigrant
mothers felt very isolated here in the United States. One woman stated that her isolation was “the most painful experience of the move” (Clark et al., 2011). This isolation directly affects the health care of their children. The women expressed that in their countries of origin, they consult their mothers or grandmothers prior to taking their children to the doctor. Many times, their mothers would come to the house, look at the child, and then bring some sort of herbal remedy or alternative treatment to help the child’s condition improve. Now that the women have lost that social support, their children have lost the health care. One woman expressed that she trusted her mom more than any doctor, and now she does not know whom to trust. The health care provider can assist in this situation by helping the Latino clients network within their community. This may prove to be difficult since the average age of the Hispanic citizen is 28 years old. If a matriarch may not be found, the health care provider can direct the client towards other people that she may learn to trust.

Recognizing the Latino lifestyle will also aid the medical professional in providing culturally competent care. The Official Journal of the American Academy of Pediatrics published an article in June of 2008 that said 33% of the Hispanic children in the US are overweight, compared to 19.5% of the white population (Flores, 2008). This is largely due to the traditional Hispanic diet accompanied by a sedentary lifestyle. The medical professional can assist the Hispanic client in making healthier diet choices within their own cultural menu. An example is to instruct the client to try whole grain rice instead of fried or white rice. Many of the foods that are traditionally fried in Hispanic cultures can also be grilled. Helping the client to recognize that they are not changing their diet, they are just modifying how it is prepared.
Exercise is also a topic that must be addressed. There is a huge emphasis (especially for women) on social gatherings and conversation. While this is healthy for the mind and soul, the body is being deprived of exercise. Teaching the clients that they can still socialize at the gym or while taking a walk would be a huge motivator for the Hispanic population. Lastly, many of the women are confronted with the issue of weight once they come to America because their caloric expenditure changes so much upon arrival to this country. Many of them come from impoverished areas in their communities. They had to work to cook food, work to get water, and work to wash clothes. This is not so in America. Now the women are suddenly gaining weight because they are not working so hard to live. Explaining this dynamic to the Latina client would greatly benefit her understanding of her own health.

*Public Health Nursing* published an article entitled, “Latina Mothers’ Beliefs and Practices Related to Weight Status, Feeding, and the Development of Child Overweight” in April of 2011. Through interviews and focus groups the researchers discovered that many of the women felt pressure from the cultural backgrounds to have “healthy children.” In their societies, eating a lot and “cleaning your plate” is favored because it means the child will grow up to be strong and healthy. As a result, these women alluded to the fact that they have forced their children to overeat in order to be “healthy” (Lindsay, 2011). The health care provider can take this opportunity to teach the mother about a healthy weight and how health is more than just the amount of food that is consumed.

*The Journal of Minority Health* published an article in 2011 that addressed another aspect of health care for Hispanics. The article is entitled “Navigating a New Health Culture: Experiences of Immigrant Hispanic Women.” The research revealed that many of the women felt
that American health care is limiting and restricting. The women surveyed had immigrated to the United States and really missed certain services they employed at home such as “folk healers, bone setters, spiritualists, lay midwives, massage specialists, and herbalists” (Sanchez-Birkhead, 2010). The American health care provider may address this issue by suggesting massage therapy or herbal remedies when it is appropriate.

Many studies also show that the Hispanic population feels a significant amount of perceived discrimination in the health care setting. In an interview of 20 Hispanic women conducted in 2010 by Ana Sanchez-Birkhead, 15 of the 20 women reported that discrimination from the health care environment discouraged them from going to the doctor. One of the women stated, “They see you Hispanic appearance and they suddenly stop what they are saying or doing and look at you... they don’t stop and look at you if you are white” (Sanchez-Birkhead, 2010, p. 1171). The women ascertained that this “treatment they received or did not receive created emotional barriers and affected the way they made decisions about seeking health care” (Sanchez-Birkhead, 2010 p 1171).

Another setting in which Hispanics feel discrimination is when calling 911. In 2010, Jennifer Watts conducted her study entitled “911 (Nueve Once): Spanish-Speaking Parents’ Perspectives on Prehospital Emergency Care for Children.” She discovered a significant area of discrimination. More than one of the women she surveyed had been asked for their social security numbers when they called 911. Upon hearing their accents, the operator questioned their citizenship, delaying the response time to the emergency. Regardless of whether or not they were illegal, these women were “stamped” with the illegal immigrant status, thus delaying health care for their children (Watts, 2011).
Another issue that Watts discovered was the Hispanic population’s understanding of how health care operates in the United States. During her studies she discovered that of her 49 participants only 49% had called 911. The primary reason for calling 911 was for noise disturbances. The other reasons were for motor vehicle accidents and robberies. Very few women actually used 911 for health care purposes because they did not understand what was considered an emergency. The 49 participants revealed that they had learned about 911 through their children from what they had learned at school. Knowing this, the health care provider can take a brief two minutes and ask the Hispanic population if they would like education on 911.

Lastly, all of these factors are influenced by one underlying theme: the concept of acculturation. In an article entitled, “The Foreign Language Anxiety in a Medical Office Scale: Developing and Validating a Measurement Tool for Spanish-Speaking Individuals,” the author, Lisa Guntzviller, utilized a scale called the “Short Acculturation Scale for Hispanics” (SASH). This scale was created in 1987 and assesses a person’s acculturation level by measuring three factors: language use, media, and ethnic social relations. What Guntzviller et al. discovered is that the more acculturated an individual is, the more satisfied they are with their health care, the higher income they have, the better insurance they possess, and the more English they speak. Assessing a patient’s level of acculturation greatly determines the health care provider’s understanding of the patient’s individual situation (Guntzviller, 2011).

Next, it is important to address socio-economic barriers that influence the health care of the Latino population. The National Survey of Children’s Health was completed in 2007-2008 and was a survey of 69,901 children in the United States. The results are displayed in a table with three separate groups: the Latino with Spanish-Language Interview (SLI), the Latino with
English-Language Interview (ELI) and the Non-Latino White population. The number of Latino children represented in the SLI group is 3,959. The ELI group was 6,772 children, and the Non-Latino White population was 59,170 children. When looking at income, 56% of the SLI children lived in families that made less than or equal to 100% of the Federal Poverty Line (FPL). This level of poverty drops significantly when moving to the ELI group with 18% living in families making less than or equal to 100% of the FPL. Finally, that number is cut in half when looking at the children of Non-Latino Whites. Only 9% of those children live at less than or equal to 100% of the FPL. The numbers are inverted, however, when looking at those families that live on 200% or more of the FPL amount. Only 10% of the SLI children live with this income. This is compared to 57% of the ELI children and 75% of the Non-Latino White children (DeCamp, 2011).

Another important statistic to look at is health insurance coverage. Only 13% of the SLI and 54% of the ELI children have continuous private coverage, while 74% of the Non-Latino White children have it. The majority of SLI children have continuous public coverage at 51%, while 27% of the ELI children do and 15% of the Non-Latino White children do. This leaves 19% of the SLI children that are uninsured, while 4% of ELI children are uninsured and 2% of the Non-Latino White children are uninsured. These disparities are predominant factors for the decreased rate of preventative health care usage in the Latino population and the perceived health status of the Latinos. Twelve percent of the SLI parents reported their children’s health status as being “fair or poor,” while this number was 4% for ELI and 2% for Non-Latino White children (DeCamp, 2011).
Looking at the mother’s education level also relates to the health status and insurance provider type. In the SLI population, 57% of the mothers have less than a high school education, 12% of the ELI mothers fall into this category and 5% of the Non-Latino White mothers fall into this category. Only 14% of the SLI mothers have more than a high school education, and 58% of the ELI mothers and 72% of the Non-Latino White mothers are in this group. It is important for the health care provider to assess the mother and father’s education level in order to format the patient-family teaching style. If the child’s parents are not well-educated, the provider will need to spend more time explaining health care instructions to the client and family (DeCamp, 2011).

The last issue that DeCamp addresses is the issue of a “medical home.” A medical home is a family’s primary care provider or family doctor. Research shows that those who have a medical home have better screenings, immunizations, and other forms of preventative care. Only 25% of the SLI children had medical homes, compared to 51% of the ELI children and 68% of the Non-Latino White population. Knowing this information allows the health care team to emphasize the importance of a medical home with Hispanic clients and gives them the opportunity to connect the family with a doctor that suits their needs.

Language is the most obvious barrier that the Latino population faces when it comes to health care. The Journal of Health Care for the Poor and Underserved found that 48% of their Latino sample of 69,901 kids speak Spanish at home. The article also reported that 62% of non-English speaking children in the United States speak Spanish at home, making Spanish the second most common language in the United States (DeCamp 2011). These numbers present the reality of the language barrier in the United States.
In Watt’s article “911 (Nueve Once): Spanish-Speaking Parents’ Perspectives on Prehospital Emergency Care for Children,” it was discovered that “many felt unable to think enough to speak even minimal English when in a state of panic and confusion” (Watts, 2011, p. 529). Some women interviewed stated that they did not believe Spanish-speaking translators would be available when calling 911. Others said that they had been forced to wait on hold until a Spanish speaker was available. Lastly, other women resorted to handing the phone to their children who speak more English than themselves. This, they stated, became quite inappropriate, especially when they were reporting intimate partner violence (Watts, 2011).

Flores and Tomany-Koram published an article in June of 2008 entitled, “The Languages Spoken at Home and Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children.” It was determined that the Latino client’s health care is greatly determined by their English proficiency. In the conclusion of the article, it was stated that:

Compared with English Proficient Language children (EPL), Non-English Proficient Language children (NEPL) experience multiple disparities in medical and oral health, access to care, and use of services. NEPL children are substantially more likely to live in low-income households, suggesting that clinicians who care for NEPL children should inquire about family income and consider referrals to programs documented to benefit poor children (Flores, Tomany-Korman, 2008 p e1713).

An article published by the Journal of General Internal Medicine in 2011 addresses another issue regarding the current language barrier: each individual health care provider’s interpretation of their own Spanish language proficiency. The study surveyed 68 health care providers in California, asking them to self-rate their Spanish proficiency. It was discovered that those who reported themselves as having a low-level of proficiency (n=34) almost always used
an interpreter for their interactions with the patients. In addition, those that rated themselves with high-levels of proficiency (n= 16) almost always used their own Spanish. This leaves the 18 participants that rated themselves as medium-level proficiency. They reported that they usually rely on their own Spanish skills for many occasions including morning pre-rounds (93%), obtaining a medical history (50%) and updating the patient on their clinical condition (55%). The article stated very strongly:

The degree of language proficiency required by a clinician to provide safe and effective care in that language has not yet been determined and thus, no standards exist to guide clinician behavior after taking language courses (Diamond et al. 2011, p. 121).

The researchers go on to say that if studies can be done to demonstrate a strong correlation between a self-reported proficiency and actual proficiency, it may not be necessary to develop strict national standards. No such research has been done, however, health care providers need to strongly consider if they do in fact know enough Spanish to be fair to their clients. This information cautions the health care provider to take the necessary measures to obtain adequate certification to speak medical Spanish in order to do what is right by the patients.

All of these factors greatly influence the health and wellness of Hispanic children in the United States. In the previously mention article by Flores and Tomany-Koram published in June of 2008 entitled “The Languages Spoken at Home and Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children”, a table was included to demonstrate the significance of the health disparities in the Latino population. Of 6,182 Hispanic children 33% are overweight or obese compared to 19.5% of the white children (n=383). In addition, only 31.5% of this same Latino population reported that their children’s health is excellent, in comparison to 62.8% of the white population. Only 18.7 % of the Latinos reported excellent
teeth condition in their children while 47.5% of the white population said their children’s teeth were in excellent condition. When it comes to dental insurance, 59% of the Hispanic population has dental insurance versus 69% of the white population. This disparity is greater with overall medical insurance. Twenty-nine percent of the Hispanic population does not have any sort of medical insurance and 50% has public health insurance. This is compared to 16.5% of the white population having no insurance, while 23.9% has public coverage. When asked if they received all needed medical care, the numbers were almost the same at 98.2% for the Hispanic population and 99.6% for the white population. This demonstrates that either the Hispanic population has a lower standard for “all medical care” or that they rely on governmental programs to assist financially in their health care (Flores, Tomany-Koram, 2008).

Common adult health care issues in the Latino population also have an effect on the Latino children. In the previously mentioned article by William A. Vega et al., it was reported that in the United States, 33% of adult Hispanics (compared to 24.6% of all Americans) die from diabetes mellitus (DM). Since DM is hereditary it is necessary to address this disparity and unusually high number when discussing screens that Latino children should get when they are older. The next highest causes of death in the Hispanic population with a strong disparity compared to total population are stomach cancer (13.6% vs 8.6%), liver cancer (16.2% vs. 10.4%) and cervical cancer (3.2% vs. 2.5%). These disparities must also be addressed to the parents regarding their children in order to take the preventative steps necessary to decrease the rate of mortality by these types of cancer (Vega, 2009).

These issues prompt one to question what is being done about these disparities.

"Introduction: Health and Human Service Delivery to Limited English Proficient and Immigrant
Communities: Policy, Management, and Educational Issues” by Frates and Saint-Germain address this exact question. Published in 2004, the article discusses national policies and organizations that have been created to address the situation. The issue was first addressed in 1964 when Title VI of the Civil Rights Act of 1964 was passed. It stipulated that no one can be discriminated against based on race, creed, color, or national origin. It also mandated that each person is entitled to verbal and written language assistance at no cost. Then, in 1985, the United States Department of Health and Human Service Office of Minority Health was created in order to address minority disparities. This branch of the Department of Health developed policies in 1999 that each health care provider needed to abide by. They were as follows:

1. Offer and provide language assistance services at no cost to Limited English Proficiency (LEP) patients at all points of contact in a timely manner during all hours of operation.

2. Provide LEP patients both verbal offers and written notices of their right to receive language assistance services in their preferred language.

3. Assure the competence of language assistance services provided to LEP patients by interpreters and bilingual staff, using family and friends only at the request of the patient.

4. Make available easily understood patient-related materials, and post signage in the languages of the commonly encountered group(s) in the service area (Frates, Saint-Germain, 2004, p. 5).
While these policies are directed towards providing clinical, ethical, and social justice to the LEP population, they have not been regulated and are therefore ineffective. In order for them to be regulated, they must be measurable. This presents quite a challenge to the American health care system, and a solution is not easily identifiable. These policies created in 1999 create a foundation for the regulations that must follow. First, a method of assessing the application of these policies must be in place. Secondly, those assessing must have a measurable format to guide the assessment. "Timely manner" should be taken to a more specific level and should have a specific time frame identified. "Competence" of the interpreter should be determined by obtaining a national certification that is required to speak any medical terms in that language. Lastly, "commonly encountered groups" should be stipulated by a certain percentage of the population. These changes would promote competent care and cultural justice for the LEP population. The solution must be addressed on a national level considering the financial cost of the resolution.

Individual hospitals have also made changes to their policies in order to provide for the LEP population. For example, there is an emphasis on hiring bilingual and bicultural health care providers (Frates, Saint-Germain 2004). Other hospitals have created medical Spanish courses that one must take in order to obtain certification in that language. Lastly, hospitals and universities alike have started creating medical Spanish (and other language) classes that health care providers may take. This, however, poses a risk considering that those with moderate proficiency tend to use their own Spanish skills, as noted previously.

While the government and hospitals are working on solutions to the current conditions, there are actions that each individual may take as well. The first is to understand one’s
proficiency level in the language, making it a priority to use translators unless a translator certification has been obtained by the individual. While this takes extra time and money, it raises the level of care to a higher level for the patient and is a moral obligation. Secondly, individuals can assess the acculturation levels of their Hispanic patients, knowing that different levels of acculturation respond differently to the same quality of care. Individuals can also make it a priority to study the cultures that are most encountered in that area of practice. While an individual patient cannot be stereotyped into a group, it helps the health care provider to direct questions to better understand the individual. Lastly, a new idea of “cultural humility” has begun to replace the idea of cultural competence. This mindset teaches the health care provider to conduct client-focused interviewing to better understand the patient’s own culture. It also requires a significant amount of self-reflection on behalf of the provider. The provider must identify what his or her own beliefs and value systems are and how they perceive their patient’s beliefs based on his or her own. In an article published by the California Health Advocates in April of 2007, the author states:

Providers are encouraged to develop a respectful partnership with each client through client-focused interviewing, exploring similarities and differences between her or his own and each client’s priorities, goals, and capacities. In this model, the most serious barrier to culturally appropriate care is not a lack of knowledge of the details of any given cultural orientation, but the providers’ failure to develop self-awareness and a respectful attitude toward diverse points of view (California, 2007).

Cultural humility is a concept that can extend beyond that of providing care for Latino clients or even LEP clients. It is a mindset and technique that should be used with every
individual patient. American health care providers have an opportunity to reach more cultures, religions, and ethnicities than ever before. As America continues to grow and mature, the health care system must as well. Through using translators, assessing acculturation, studying cultures, and practicing cultural humility, American health care providers are equipped and prepared to meet this challenge. For fairness and equality have been the foundations of America since its birth.
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