COMMUNICATIVE NEEDS OF ENGLISH-SPEAKING HEALTH CARE
PROFESSIONALS WHO WORK WITH SPANISH-SPEAKING CLIENTS: A CASE
STUDY

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
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*****

The Ohio State University
2003

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ABSTRACT

Over the course of three years, a qualitative case study was conducted in a series of three perinatal clinics in one metropolitan area in Ohio. Through an in-depth examination of five health care professionals in a clinic setting, the study focused on the common linguistic and cultural needs of this group and how to address their varying Spanish-language needs. Specifically, the researcher examined the nature of communication in a health care setting, the Spanish language acquired by the health care professionals, how they acquired needed Spanish language, their linguistic needs, their cultural needs, issues of reciprocity related to Spanish and English languages of communication, and issues of power related to Spanish as the language of communication. Data in the form of participant observer fieldnotes, participant interviews, document analysis, and member checks were collected and triangulated. Data were then coded and managed using NUD*IST software.

Results indicated that participants were able to produce routinely used words and common expression in Spanish, but they were only able to understand isolated lexical items when they were spoken in Spanish by native speakers. Their needs included written resources formatted for optimal use in the health care perinatal clinic workplace, strategies for developing listening skills, and awareness of cultural differences.
It was concluded that an imbalance was revealed in productive and receptive abilities on the part of study participants (e.g., health care participants) indicating that the commonly accepted theories of comprehensible input and comprehensible output models may not apply to the participants in this clinic setting.

Implications for instruction include a focus on strategies that facilitate on-the-job learning beyond the typical academic context, an approach to productive language skill development that involves referring students to appropriate resources and assisting them in formatting information so that it will be useful in the perinatal clinic workplace, a focus on receptive skills, beginning with receptive strategies in interactive listening that allow for continuation of communicative interactions while also demonstrating the limits of receptive abilities, and possibly integrating autonomous language learning with clinic workplace interactions.
ACKNOWLEDGMENTS

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The Department of Spanish and Portuguese at The Ohio State University made my pursuit of this degree possible with ongoing financial, academic and professional support. I would particularly like to thank my mentors in that department who preceded me in this same degree program: Leslie Ahmadi, Donna Long, Jan Macián, and Jill Welch.

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Finally, I thank my family and friends who supported me throughout my pursuit of the Doctoral Degree, especially my husband, Bill Krug, and our daughter, Nancy Kimberley Krug.
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FIELDS OF STUDY

Major Field: Education
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CHAPTER 1

INTRODUCTION

1.1 Introduction and organization of the dissertation

With ever increasing urgency, various professions call for their practitioners to use more than one language on the job in the United States. Voght and Grosse (1998) argue that foreign language education will have to “focus on the needs of the majority of our college students, who will not be educators, but businesspeople, international lawyers, medical professionals, social workers, and other professionals” (p. 9). According to Voght and Grosse (1998), language education that is related to the professional interests of the learners attracts more students to study language and culture because they see the connection between their career aspirations and second language and culture knowledge (p. 11). However, the void between English-speaking professionals already working in their fields and their clientele who do not speak English continues to grow. These working professionals do not have access to the same kinds of academic programs as students preparing for their professions. Working professionals have unique needs in two respects: the specific linguistic and cultural knowledge required for them to communicate with clients and the practical aspects of fitting language and culture education into their professional lives.
Of particular interest in this study is Spanish language and culture education for the health care profession, a field that reflects the unique needs of professionals. It is also a field in which the need to close the communication gap between professionals and clients is urgent (González-Lee, 1992; González-Lee, 1998; Jonsson-Devillers, 1992; Kothari and Kothari, 1997; Mason, 1991). Large numbers of Spanish-speaking patients for whom “the utilization of health care services is largely affected by cultural beliefs, insurance status, language of communication, and income” (González-Lee, 1998, p. 324) are already filling clinics and hospitals throughout the United States. Even if professional schools and university language programs have begun to respond by addressing issues of cultural beliefs and language of communication for their students (Jonsson-Devillers, 1992; González-Lee, 1992; González-Lee, 1998; Mason, 1991), those already in the health care profession who are no longer college students need specific linguistic and cultural knowledge in order to successfully communicate with their clients.

This study provides an in-depth examination of one health-care setting in which English-speaking health care professionals serve Spanish-speaking clients. Though quantitative measures such as surveys and questionnaires can be used to solicit learner intuition regarding their linguistic and cultural needs, this qualitative study explores the learners’ needs beyond their own intuition. In professional settings in which English-speaking health care professionals need to communicate with Spanish-speaking clients, the specific communicative needs of each individual will vary. Through an in-depth
study of five individuals in one clinic setting, this study will focus on the common needs of this group of health care professionals and how to address varying individual, unique needs in a classroom setting.

Chapter one serves as an introduction to the study and includes a statement of purpose, definition of terms, research questions, basic assumptions, limitations of the study, a brief overview of the research methodology, and the significance of the study to the profession. Chapter two includes a review of the relevant literature, with a focus on three areas: Spanish for specific purposes, English for specific purposes, and the role of listening in second language acquisition. The first two examine the state of existing language programs for professionals while the third focuses on the receptive aspect of oral communication, which practicing professionals need in order to facilitate communication with clients. Chapter three describes the methodology used in this study. It includes descriptions of the qualitative case study that was employed, the sampling and sampling procedures, the paradigmatic and methodological assumptions, the data gathering techniques, trustworthiness and ethical issues, a description of data analysis procedures, and an account of the pilot study. In chapter four the research questions are revisited in the discussion of results. Chapter five presents a summary, conclusions, and recommendations for further research.

1.2 Statement of Purpose

An in-depth examination of a real world professional setting should provide insight into how to serve the growing Spanish language and cultural needs of current and
future health care professionals. The data collected through a qualitative case study of a perinatal clinic will be used to:

- examine the current culture of a health care setting in which Spanish-speaking clients are routinely served,
- analyze the linguistic and cultural needs of English-speaking health care professionals who increasingly serve a Spanish-speaking patient population, and
- interpret the results and propose a framework aimed at assisting the development of curricula for specific health-related purposes programs.

According to Erickson’s (1986) article, “Qualitative methods in research on teaching,” the first of the above objectives is general description, the second, particular description, which is essential because it warrants one’s assertions, and the third, interpretive commentary (p. 149). All three are vital to valid and trustworthy qualitative research.

1.3 Definition of terms

The following terms are used throughout the study. In this section they are listed alphabetically and followed by a definition that aligns with their usage in this research.

**case study**: an in depth qualitative study of one situation or environment. The researcher is immersed into specific communities and researches the community as it is experienced.

**client services**: those things that fall under the purview of appropriate aid or assistance rendered to patients by health care professionals. Client services are context dependent. For example, in some situations transportation may be a client service but in others it may not.
**cultural barriers**: those difficulties caused by interlocutors possessing different traditions and practices with neither knowing enough about the culture of the other to successfully communicate.

**cultural care diversity**: the suggestion that culture-specific care might be provided by medical professionals whose training includes instruction in care that varies culturally according to folk beliefs.

**cultural knowledge**: the understanding one has of traditions and practices. One may possess knowledge of one’s own culture, but lack knowledge of another culture.

**emic perspective**: an “insider” perspective that recognizes both the importance of research participants’ understanding of their own culture and the fact that such understanding is culturally relative. In this study, the research participants are health care professionals in a system of perinatal clinics.

**etic perspective**: the researcher’s “outsider” perspective that does not seek cultural understanding from the perspective of research participants.

**framework**: a patterned structure that might be applied to various situations. In this case, framework refers to Spanish for specific purposes curricula.

**grounded study** “systematic inductive guidelines for collecting and analyzing data to build middle-range theoretical frameworks that explain the collected data. Throughout the research process, grounded theorists develop analytic interpretations of their data to focus further data collection, which they use in turn to inform and refined their developing theoretical analyses” (Charmaz, 2000, p. 509).
**health care field**: those professions characterized by the provision of medical services to patients. In this study, the health care field is perinatal care for women who are expecting or have recently had a child.

**health care professionals**: employees in a medical professional workplace who have been trained to provide medical services of some kind.

**interaction**: intentional contact in which two parties engage one another, usually having a common goal as the designated outcome.

**language acquisition**: the process of developing linguistic skills, including reading, writing, listening, speaking, and culture, that allow for communication in a given language. This study examines Spanish language acquisition on the part of health care professionals, with a focus on listening, speaking, and culture skills.

**language barriers**: those difficulties caused by interlocutors possessing different native languages with neither fluent enough in the language of the other to successfully communicate.

**linguistic knowledge**: the understanding one has of the workings of a language.

**medical professional workplace**: a place of employment in which health services are rendered by those trained to provide such services. In the case of this study, public perinatal clinics are the medical professional workplace.

**native language**: the first language one learns, native language is the language used by those surrounding a child as it learns to speak. Often it is the national language of the country in which one is born.
non-English speaking: those characterized by having both a native language other than English and not being able to use English to successfully communicate with someone who does have English as a native language.

NUD*IST: (Non-numerical Unstructured Data * Indexing Searching and Theorizing) - computer software for management of textual data produced in qualitative research.

patients: those who seek medical care from a medical professional work place, in this case public perinatal clinics. The patients in this study are women who are expecting a child or who have recently had a baby.

patients’ language acquisition: the process of developing linguistic skills, including reading, writing, listening, speaking, and culture, that allow for communication in a given language. This study does not examine English language acquisition on the part of Spanish-speaking patients.

power dynamics: the manifestations in a relationship of authority bestowed on one party based on rank or status.

professionals: those who have been trained within a specific field of work and earn a living through their work in that field. In this study, the professionals are health care professionals in a perinatal clinic.

programs and institutions: the potential sources of language courses for working professionals, such as community colleges, municipal organizations, community organizations, and local departments of parks and recreations, as well as colleges and universities.
**qualitative case study**: detailed description of persons, places and events in a particular setting based on the researcher’s presence and participation in the setting.

**reciprocity**: the characteristic of a relationship by which interactions are mutually beneficial. In this study, reciprocity refers to communicative reciprocity in which both parties contribute to attempts at successful communication.

**role**: the capacity fulfilled by one’s presence in a given situation based on that person’s title, qualifications, or circumstances. The same individual may fulfill different roles in different contexts or multiple roles in a single context. In this study, the participants’ roles include registered nurse, doctor, medical student, nurse midwife, nutritionist, and social worker.

**script**: refers to a set of fixed expressions used repeatedly by the participants in the clinic setting, as coined by a participant; not the schema theoretic usage of the term.

**undocumented residents**: those people from countries other than the United States who are living in the United States, but who do not possess the appropriate paperwork to reside here legally.

**university language curricula**: the programs used by foreign language departments at post-secondary institutions of education to teach foreign languages in the classroom.

**universality theory of nursing** theory that suggests that though nursing care varies culturally according to folk beliefs, universals in professional nursing care exist and can be taught.
1.4 Research Questions

The research questions that guide the present investigation are listed below.

1. What is the nature of communication between health care professionals and patients in a perinatal clinic when the two parties do not share a native language?

2. In learning Spanish on the job, what linguistic structures are acquired by health care professionals?

3. In learning Spanish on the job, what are the processes through which the acquisition of linguistic structures takes place?

4. What are the linguistic needs of the English-speaking health care professionals in the perinatal clinics?

5. What are the cultural needs of the English-speaking health care professionals in the perinatal clinics?

6. Is there reciprocity between the English-speaking health care professionals and their Spanish-speaking patients in their attempts to communicate in the clinic setting?

7. What power dynamics related to language of communication are at work in providing client services?
   A. How do the power dynamics differ according to an individual’s role in the clinic?
   B. How do the interactors cope with power dynamics?
1.5 Basic assumptions

The basic assumptions underlying this study include the following:

1. Language and cultural barriers complicate the rendering of client services in the health care field.

2. The need exists for increased linguistic and cultural knowledge in the medical professional workplace. This need has reached critical proportions for Spanish-speaking patients in the United States.

3. Health care professionals want to gain linguistic and cultural knowledge in order to communicate with their patients.

4. Case study is an appropriate methodology to obtain an emic perspective for the present study.

5. Age was not deemed to be a factor, as all participants were adult learners who had passed any critical period that may exist.

1.6 Limitations of the study

Because this is a qualitative study, the results are not generalizable beyond the participants in the study. Even within the health care profession generally, and the provision of perinatal care specifically, the participants in this study may not be representative. The participants who agreed to participate in this study were the most motivated professionals in the setting with regard to learning Spanish.

While part of this study examined strategy use, a longitudinal follow-up study would be required to determine the effectiveness of strategy instruction and implementation over time. In the context of a Spanish course for medical professionals, a
pre-test, post-test design could measure immediate effects of instruction. However, since the formal instruction offered during this study was spontaneous in nature, such tests were not administered.

Though their insights may have been helpful to this study, patients have not been included because of confidentiality issues in medical settings. Likewise, patients’ language acquisition was not deemed to be a feasible factor in this study because of patient confidentiality issues as well as the difficulty of obtaining approval to interview the Spanish-speaking clients who need medical services.

1.7 Research methodology

In this study, a qualitative case study has been used to provide an in-depth description of the communicative needs of health care professionals working with Spanish-speaking clients in perinatal clinics. Observations, interviews, document analyses, and member checks were used to try to develop a framework that would be useful in Spanish language and culture curricula for health care professionals. The participants were a sample of the health care professionals working in the four public perinatal clinics (nurses, nurse midwives, and a nutritionist) in a large city in the Midwest part of the United States. As the fieldnote and interview data were collected over a period of seven weeks, the data were managed using NUD*IST software. The data were coded, triangulated, and analyzed following the premises of grounded theory.

1.8 Significance of the study

Voght and Grosse (1998) argued that designing courses for specific professions rather than the standard fare of Spanish literature and linguistics benefits all parties
involved. For the students, “when foreign language studies focus on career goals, many more students go on to develop meaningful levels of foreign language proficiency and cross-cultural understanding, with all the personal and professional benefits that such abilities carry with them” (p. 10). For the departments, “by broadening the appeal of language and cultural studies, offering Spanish and Portuguese for Specific Purposes can significantly increase the numbers of students in language classes. As the pool of language learners increases, the numbers of students in traditional classes can grow as well” (p. 10). Voght and Grosse’s argument is compelling for college students who are preparing for their professional lives, but working professionals have limited time and resources with which to pursue language and culture education. Language and culture courses for those already in the workplace would have to accommodate the circumstances of their professional lives, even as such education becomes more and more crucial to success on the job.

Recent media reports emphasize the increasing importance of multilingual communication in the workplace. In an August 20, 2002 article, “Learning the New Language of Labor,” the Washington Post suggested that bilingualism is the inevitable solution to communication problems in the workplace. The article cites one Maryland county that “at first hired bilingual Latino liaisons for different departments,” but now acknowledges that it “need[s] people who speak more than one language” (p. 3). The Washington Post reports that “area governments are sponsoring classes” and cites
community colleges as the source for “a new kind of brief, work-oriented course: construction Spanish, health care Spanish, restaurant Spanish or firefighter Spanish” (p. 1).

A June 22, 2002 New York Times article, “Limited English Can Hurt Patients,” explores the communicative void in medical settings where English-speaking health care professionals are not always able to successfully communicate with non English-speaking patients. The American Medical Association is quoted as favoring thorough provision of health care through successful communication with patients, but objecting to the high cost of interpreters (p. 3). In a December 21, 2001 letter to the Office of Management and Budget regarding access to healthcare for individuals with limited English proficiency (LEP), the American Medical Association asserted that the policy guidance of the Office of Civil Rights of the Department of Health and Human Services that physicians who receive federal financial assistance must cover the cost of trained interpreters for all LEP patients could actually “reduce, not strengthen access to health care services for LEP patients” (p. 1). While emphasizing that “clear, direct communication and understanding is the bedrock of the patient-physician relationship” (p. 1) the letter cited severe economic losses for physicians--who receive between $30 and $50 for a Medicaid office visit, but would have to pay between $30 and $400 for interpretation services--as the reason for objecting to the policy guidance.

A clear national policy on how to best render medical services to patients with Limited English Proficiency has not emerged. The New York Times article, “Limited English Can Hurt Patients,” reported that while local and state laws that enjoy varying
levels of enforcement may require bilingual services or translation of vital documents, national government guidelines are not yet in place regarding services to LEP patients (p. 2). In the meantime, “doctors rely on a patchwork of methods for communicating with patients who don’t speak English,” such as having non-medical staff or relatives interpret or using flashcards (p. 3). Clearly, some level of communicative competence in the patients’ language would contribute to the successful rendering of medical services.

Increasingly, the language needed to communicate with patients is Spanish. Census data (American FactFinder; Ohio Department of Development, Office of Strategic Research, A State Affiliate of the U.S. Census Bureau; see Table 1.1) confirms an increase in the Hispanic population, which often means a corresponding increase in Spanish-speakers. In the United States the reported number of Hispanics increased by 57.9% between the 1990 and the 2000 census while the general population only increased by 13.1%. In this state, the reported number of Hispanics increased by 64.5% between the 1990 and the 2000 census while the general population only increased by 4.7%.

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<tr>
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Table 1.1 Increase in Hispanic population
When this population of Spanish-speakers seeks medical care from English-speaking health care professionals, communication difficulties can complicate the rendering of patient services. The increased demand for medical professionals with communicative proficiency in Spanish ("Limited English," 2002) might put demands on various educational programs to prepare students to use linguistic and cultural knowledge in professions. Through close examination of one professional setting, this grounded study determined some specific limitations and needs of one group of health care professionals in their pursuit of Spanish language and cultural knowledge. The results could influence language programs seeking to serve the population of professionals and professional students who increasingly require such knowledge.
CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

While the importance of real world applications of language learning is emphasized throughout the literature on languages in the professions, little research exists on those professionals who already reside in the “real world.” In her chapter in the book Spanish and Portuguese for business and the professions entitled “Medical and health care fields,” González-Lee (1998) pointed to high achievement among university Medical Spanish students who apply their studies in clinical settings, but nowhere is the reverse situation addressed, namely clinical settings in which motivation to learn other languages and cultures may be high, but no formal instruction is available. Such clinical settings are appropriate places for language instruction.

To understand both the existing programs for and the likely needs of such professionals, the following literature review explores three areas: Spanish for specific purposes, English for specific purposes, and the role of listening and strategy use in theories of oral communication in second language acquisition. The first two examine the unique nature of existing programs while the third addresses the fact that practicing professionals need Spanish in order to facilitate oral communication with clients. This
study explores the divide between learning to produce the relevant professional vocabulary and understanding the clients’ spoken responses.

### 2.2 Spanish for Specific Purposes

A number of studies in language and culture training for professional preparation have been conducted on undergraduate or postgraduate university students (Jonsson-Devillers, 1992; González-Lee, 1992; González-Lee, 1998; Mason, 1991; Voght and Grosse, 1998). The academic programs examined in those studies were designed based on consultations with various academic departments, but working health care professionals themselves have not been consulted. For example, in González-Lee’s (1992) discussion of programs in Spanish and Cultural Sensitivity for graduate and undergraduate medical students offered at the University of California, San Diego, she stated that “the faculty at the School of Medicine [and] Department of Community Medicine sought the advice and expertise from the Department of Linguistics and the Latino Medical Community” (p. 2). Hendrickson (1986) advised assessing the needs of working professionals by administering a questionnaire on the first day of class (Hendrickson, 1986), but beyond that there is a paucity of research on Spanish language and culture education for practicing health care professionals. The need persists for in-depth studies to determine what practicing health care professionals’ needs and wishes are and how those can be reconciled with programs and institutions as they attempt to serve the linguistic and cultural needs of those health care professionals.

According to González-Lee (1998), health care professionals “have a need for direct communication with their patients because trust is a determining element in patient
compliance and resolution of illness” (p. 327). The perceived need of the learners should not be prescribed from the outside; the learners themselves should be consulted. In her book, *The communicative syllabus: Evolution, design and implementation*, Yalden (1987) suggested that in any needs assessment conducted prior to constructing a curriculum, “the purpose is to obtain as much information as possible in any given situation about the learners and about their purposes in acquiring the target language” (p. 103).

In identifying learners’ purposes and needs, the existing literature repeatedly mentions time constraints, a lexical content that specifically and exclusively addresses medical Spanish, the predominance of oral/aural skills, and cultural knowledge needs. In programs for medical students, attrition rates are often attributed to lack of time (González-Lee and Simon, 1987; Jonsson-Devillers, 1992; Nora, et al. 1994). Palmer and Shawl (1978) wrote that “the health care professional usually does not have sufficient time to complete established course sequences” (p. 496) in Spanish. Any program that is to reach practicing health care professionals should take their busy schedules into consideration.

Because they will use Spanish in the workplace, health care personnel need medical vocabulary and expressions. In her description of a medical Spanish training program at the University of California, San Diego, Jonsson-Devillers (1992) emphasized this point when she stated that “it is important to give the medical personnel we are training immediate information relevant to their specific needs” (p. 8). In criticizing the lack of efficacy of traditional Spanish classes for medical personnel,
Palmer and Shawl (1978) suggested that practicing health care professionals “find that available courses are traditionally focused and the lexical content is removed from medical situations” (p. 496). This realization that vocabulary offered in traditional language textbooks is not appropriate for medical professionals is an important adjustment for a potential teacher of medical Spanish to make. As Jonsson-Devillers (1992) pointed out, “many traditional aspects of language teaching do not have any relevancy in a course where the most urgent is to know how to preserve or save lives” (p. 2).

The need for skills in reading and writing is negligible for English-speaking medical professionals seeking to communicate with Spanish-speaking clients. The existing literature on medical Spanish acknowledges the need “to provide the learner with as much oral/aural practice in the target language as possible” (Palmer and Shawl, 1978). With regard to skill acquisition, Jonsson-Devillers (1992) advocated developing listening comprehension first by using authentic materials and then moving to production (p.1). González-Lee (1992) listed “ability to understand…ability to use the medical context to decode meaning from patients’ language and expressions of complaints…ability to interpret verbal and non-verbal messages from patients of a different culture” (p. 4) as essential skills for health care professionals. The assertions of these authors accentuate the weaknesses of available syllabi and textbooks in the field of Spanish for medical professionals.

Over the past decade, dozens of Spanish language reference materials for medical professionals have been published. Many are medical dictionaries or collections of
important words and phrases (Kay, 2001; McElroy and Grabb, 1996; Nolte-Schlegel and Soler, 2001; Rogers, 1997). Some are deliberately designed to help English-speaking health care professionals interview Spanish-speaking patients (Bongiovanni, 2000; Espinoza-Abrams, 1992; Joyce and Villanueva, 1996) while others attempt to be self-teaching courses (Harvey, 2000; Ríos and Torres, 2001) that help English-speakers move towards bilingualism.

Medical Spanglish (Espinoza-Abrams, 1992), for example, is intended for use by English-speaking health care professionals who do not speak any Spanish and do not have access to bilingual interpreters. It consists of three columns that list short, direct yes/no questions in English, Spanish and phonetic Spanish. Use of the text is facilitated by the fact that it follows a medical interview format that should be familiar to any health care professional. Bongiovanni’s (2000) text, Medical Spanish, is also designed to allow English-speaking health care professionals avoid open-ended questions while interviewing Spanish-speaking patients. The twelve chapters that follow a two-column, English-Spanish format are preceded by a clear and systematic explanation of how to use the questioning technique provided in the book. Bongiovanni provides a complete pronunciation and accentuation guide in less than two pages and in three more pages succinctly explains basic grammar, including gender, number, possessive adjectives, subject pronouns, and common prefixes and suffixes. These books for English-speaking medical professionals that assume culture-free “yes” or “no” answers from patients
(González-Lee, 1998, p. 335) cease to be useful when the patient answers are more complicated than “yes” or “no.” They are important and useful quick-fixes, but quick-fixes nonetheless.

The materials that provide self-teaching courses offer more communicative skills to their users, but the claims may exceed the realistic results of most users. Harvey (2000) claims that the first two chapters of Spanish for health care professionals “teach you how to speak and understand Spanish almost immediately” (p. vi). While the intention is clearly to inspire self-confidence by encouraging the readers to relax and enjoy learning Spanish, suggesting on the first page that within weeks they might be, “jabbering away in español” (p. v) may set users up for disappointment. Throughout readers are encouraged to aim for a general understanding and reminded not to panic, but general understandings may not be enough in a medical setting where treatments and medicines may be prescribed based on what was understood.

In Medical Spanish: The practical Spanish program for medical professionals Ríos and Torres (2001) present a text-workbook with accompanying tapes. Besides the aural input, the program is unique in that the book relies largely on illustrations to avoid translation. The dialogues in each chapter are presented in print and aurally without a readily available translation to encourage creating meaning based on vocabulary learned earlier in the chapter. Though the dialogues are fixed, the authors point out that the dialogues are intended “to teach the basic sentence structures needed to form your own dialogues to suit your own specific needs” (p. x).
Medical Spanish: The practical Spanish program for medical professionals is a rigorous self-study course that requires starting from the beginning and moving diligently through the program. This limits its usefulness as a reference book. In fact, rather than acknowledging the limited time and resources of health care professionals, the authors admonish that “vocabulary lists are there to be learned. You should be accustomed to memorizing or assimilating vast quantities of information. (How else were you able to succeed during ‘med school’ or any medically related field of training?)” (p. xi). This rigid program contradicts the work of other scholars (González-Lee and Simon, 1987; González-Lee, 1992; González-Lee, 1998; Jonsson-Devillers, 1992; Nora et al., 1994) who assert that for medical Spanish methodological flexibility is essential, “depending on students’ learning styles and whether they are in a hospital setting or in a classroom” (González-Lee, 1998, p. 328). For example, in a classroom setting where time is limited, the communicative approach with its emphasis on speech acts over grammar instruction might be more effective, but the natural approach, in which cultural immersion is the focus, might be more appropriate for language instruction in a work setting where there is access to native speakers.

More recent literature also asserts that language instruction without culture instruction is irrelevant. The importance of the partnership between language and culture is repeatedly emphasized in the literature on medical Spanish courses (Kothari and Kothari, 1997; Jonsson-Devillers, 1992; González-Lee and Simon, 1987; González-Lee, 1992; González-Lee, 1998; Greengold and Ault, 1996; Nora et al., 1994). An excellent example appears in Nora et al.’s 1994 article, “Improving cross-cultural skills of medical
students through medical school-community partnership.” In partnership with targeted communities, a program was designed for medical students consisting of the following three components: (1) classroom instruction in medical-related language, (2) cultural competence training, including “didactic and small group sessions led by community experts who discuss a variety of topics” (p. 145), and (3) an international seminar conducted over eight days in Cuernavaca, Mexico. All students take the cultural competence component. No student can take just the language component. This is based on the authors’ belief that “language training without cultural competence has the potential to do more harm than good” (p. 145).

In medical Spanish classes for aspiring and practicing medical professionals alike it is important to teach both language and culture in order to avoid superficial treatment of either element. For medical professionals the “ability to interpret patient verbal and nonverbal behaviors in a culturally relevant way” is essential (González-Lee, 1998, p. 329). After all, in any communicative situation, listener and speaker have to share schemata in order to understand each other, which means that language alone is not enough (Rost, 1990). While linguistic knowledge and lexical items may be the foundation of communication, they do not automatically ensure that a message will be effective. The significance of shared understanding is especially relevant between patients and those who care for them. González-Lee (1998) stressed the importance of cultural understanding in forming an alliance between patients and health care professionals and includes such cultural categories as food, family structure and roles,
health beliefs and practices (including religion’s influence), views towards death, and common areas of miscommunication (p. 329).

For language students who need to communicate in the workplace, issues of language are inextricably mixed with culture. Any language course for professionals who need to communicate with clients or colleagues who speak another language must address issues of culture if the learners are going to be effective users of language. The first step is to become aware of one’s own culture and culturally learned assumptions, which “control our lives, with or without our permission” (Pedersen, 1995, p. 20). Without understanding the pervasiveness of culturally learned assumptions that are at the root of our own behavior, it is impossible to fully understand other cultures. Gimenez (2001) suggested “a framework that starts by analysing one’s own beliefs and values and then focuses on those of another culture could promote a more flexible approach as well as a more comprehensive understanding of essential issues in cross-cultural communication” (p. 188).

In teaching about cultural practices in the language for specific purposes classroom, one must be careful to neither assume sameness across cultures nor represent difference in the form of stereotypes. Especially when their own cultural assumptions have not been consciously examined, “professionals tend to assume that people’s cultures are more similar than they actually are” (Gropper, 1996, pp. 2-3). These assumptions can lead to misunderstandings over “showing respect, handling time and space, interpreting behavior and gestures, and prioritizing values” (Gropper, 1996, p. 4). For example, an English-speaker’s failure to distinguish between formal and informal registers in
Spanish—a distinction that does not exist in English—could inadvertently show disrespect to a Spanish-speaker. Likewise, a patient’s reticence out of respect for the medical professional might be interpreted as lack of interest or understanding.

There must be a compromise position between assuming sameness and invoking cultural stereotypes if professionals are going to achieve successful interaction with clients from other cultural and linguistic backgrounds. Without such a compromise, their professional aims may not be met. Pedersen (1995) summed it up in the following way:

if cultural similarities are overemphasized, the more powerful group will impose its values on the less powerful groups, ignoring the importance of one group’s unique perspectives. If cultural differences are overemphasized, stereotyped and politicized interests will be polarized against one another, ignoring the common ground of shared interests (p. 20).

Culture should be taught by specialists in language and culture as is reported in Nora et al. (1994), but other recommendations for teaching culture that have met with success in medical Spanish classes include novels, films (González-Lee, 1998), sociology and anthropology articles, patient interviews, documentary videos, and textbooks (Jonsson-Devillers, 1992).

Leininger’s work deals with the importance of cultural care in the nursing profession. Reynolds and Leininger (1993) presented Leininger’s theory which seeks to describe universals in professional nursing care so that beliefs that vary culturally might be addressed in the provision of culture-specific care (1993, p. 22). The authors argued that “culture and care are inextricably linked and that care/caring is the central concern of nurses. The goal of Leininger’s theoretical work is to provide culturally congruent nursing care” (Reynolds & Leininger, 1993, p. 14). Leininger’s cultural care diversity
and universality theory of nursing relies on qualitative methods because the perspective of nurses and those they care for are essential. The case study’s focus on the emic perspective “permits the local people’s viewpoints, ideas, and experiences to come forth” (Reynolds and Leininger, 1993, p. 18) instead of relying on the researcher’s etic perspective.

2.3 English for Specific Purposes

The language teaching profession has seen the emergence of language teaching for specific purposes. With Spanish for Specific Purposes, for example, the assumption is sometimes made that students in such classes will be from a majority culture and therefore need language skills to work with clients who sometimes come from minority cultures. Because the body of work on Spanish for specific purposes is small, this study draws on the English for Specific Purposes (ESP) literature. As technological and transportation advances have created a “global” society, that globalization has brought many professions and vocations into the international domain. The sub-field of English for Specific Purposes has emerged out of the field of English as a Second Language to meet the specific academic and professional needs of learners. Courses in ESP focus on the specific vocabulary and the unique language skills those in a given field are likely to require. For example, students in English for Medical Purposes, an even more recent sub-categorization of the field of English as a Second Language, might require instruction in medical topics, doctor-patient interactions, and dealing with medical literature in English.
An exploration of themes in ESP literature will be preceded by a discussion of the relationship between language and power. Salient themes in the ESP literature include an exploration of doctor-patient talk and the relevance of an ESP course to real world work situations. Some research in ESP has documented the perspective that traditional language classrooms may not be appropriate for learners who need to learn a foreign language for specific, professional purposes. It is essential that language for specific purpose courses be based on insights into learners’ actual language learning needs, which can be gained through qualitative needs analysis.

2.3.1 Language and Power

Increasingly, the lingua franca in our global society is English. As the language spoken in the most politically, economically, and culturally powerful countries in the world, it is viewed as the language that opens the door to all this power. So widespread is the use of English that it is often the common language of two people who do not share a native language (Kachru). This diffusion of English has lead to the concept of world Englishes and a lot of debate about Center versus Periphery English usage (e.g., Amin, 1999; Braine, 1999; Canagarajah, 1999; Kachru, 1992; Phillipson and Skutnabb-Kangas, 1996; Thomas, 1999). Those of us who are native English speakers, especially those of us born into middle-class, U.S. society enjoy the most central position in this linguistic system. Teachers of Spanish in the most privileged society in the world face the challenge of convincing students who already control the internationally dominant discourse that learning languages other than English can be meaningful and applicable. As is the case with participants in this study, students in the United States often will use
the skills they acquire in Spanish language classes within the United States. The skills required involve more than linguistic control of the Spanish language. Students must also learn the value of linguistic flexibility and the art of cross-cultural as well as cross-linguistic communication.

Traditionally, native speakers of English from Center countries not only have controlled the discourse of power, they also have controlled the diffusion of this discourse (Phillipson and Skutnabb-Kangas, 1996). At the same time, foreign language education in the United States has generally proceeded without considering the position of these languages in the international linguistic hierarchy or the students’ future use of what they learn.

Some authors seek a place of equal importance for the teaching of World Englishes as opposed to teaching Center-country standard English only. Some, like Canagarajah (1999), argue for a collaborative, democratic approach to English language education while others, like Kachru (1992), take it one step further and see World Englishes as functioning autonomously from Center domination. Phillipson and Skutnabb-Kangas (1996) argue for a language policy that promotes linguistic human rights and shuns linguicism and linguistic imperialism. This goes beyond the issues of English as a language of world power to the idea that it is the obligation of all nations and their people to not only support a democratic approach to English language education, but also to pursue multilingualism.

In his article, “Interrogating the ‘native speaker fallacy:’ Non-linguistic roots, non-pedagogical results,” Canagarajah (1999) points out that Chomsky’s ideal native
speaker who is also the ideal teacher does not hold up in this age of World Englishes (p. 78). Like Braine (1999), Canagarajah likens employment in TESOL to other forms of protectionism (p. 83). “Not only do Center institutions make money on training Periphery teachers, they eventually exclude them from these professions in order to monopolize the jobs” (p. 84). The monopoly on such things is maintained securely in the Center in part because most teaching materials and tests, such as TOEFL, reflect a native speaker, monolingual bias (p. 86).

Being a native speaker of English from a Center country does not automatically make one a good teacher of English. Despite the fact that “language teaching is an art, a science, and a skill that requires complex pedagogical preparation and practice” (Canagarajah, 1999, p. 80), native speakers of English, regardless of pedagogical training, are favored internationally. In Periphery countries, the best interest of learners may not be considered because a lot of these Center teachers are ignorant of the complex cultural, social, economical, and political climates of the communities in which they work. When the professional workplace within the U.S. requires interaction with Spanish-speaking clients, professionals must be prepared to encounter similar cultural, social, economical and political climates.

Canagarajah ultimately suggests aiming for true democracy in all aspects of English language education with collaboration among Periphery and Center teachers in order to best serve a given community’s language needs. For true linguistic democracy, however, English cannot be the only language under consideration.
In “Teaching World Englishes,” Kachru (1992) explains why English is not just for monolingual societies anymore. Precisely because English is an international language, it no longer belongs to the native speakers from Center countries; thus the term Englishes to refer to the many native and non-native varieties of English. Kachru’s attitude is that local standards of English not only merit recognition as legitimate varieties of English, but also serve important roles that have nothing to do with Center-country English. For example, it is often assumed, especially in Center countries, that English is learned internationally to communicate with native speakers; however, English is often the common language of two people who do not share a native language and therefore has its own set of conventions (p. 357).

The very existence of these conventions flies in the face of other long-held, Center-country biases with regard to the international use of English. That native-speaker proficiency should be the goal of English education ignores the practical reality that many places have institutionalized another model of English (p. 358). Many speakers of these models of English are native speakers who simply do not speak the same English as is used in Center countries (see Thomas, 1999). Rather than considering the diversity and variation of these other models of English as interlanguages that represent linguistic decay, Kachru argues that they are legitimate varieties of English (p. 358) that simply have different uses in multilingual societies than they have in monolingual societies (p. 360).

While Center-world English dominates the environment in which this study occurred, the clinic setting itself reflects the emergence of a multilingual society in which
English alone is not enough to communicate. This study will explore the nature of “other models” of Spanish that, for the purposes of working health care professionals, are legitimate and functional varieties in the social setting of the perinatal clinics.

Phillipson and Skutnabb-Kangas (1996) provide insight into how to move away from the dominant paradigm of diffusion-of-English to the less imperialistic ecology-of-language paradigm. These authors operate under the assumption that language holds power in many respects—including social, economical, cultural, and technological—and is therefore political. The diffusion-of-English paradigm results when the spread of language also implies the spread of the models of power associated with that language. Alternatively, the ecology-of-language paradigm promotes “equality in communication, multilingualism, maintenance of languages and cultures, and…promotion of foreign language education” (p. 436). First and foremost, language policies must be implemented that specifically address “decisions on rights and access to languages and on the roles and functions of particular languages and varieties of language in a given polity” (p. 434). Language policy should account for inequities in power and respect linguistic diversity (p. 435).

If the teaching of English is the only consideration, ecology-of-language has not been achieved because English will have retained its position of power. To fully implement the ecology-of-language paradigm, language policy should extend beyond the teaching of English to the acquisition of other languages on the part of English-speakers.
As Phillipson and Skutnabb-Kangas assert, “it is also obviously in the national interest of every country to invest in foreign language education for external, international purposes” (p. 445).

As a Spanish teacher in a country that is largely apathetic to the idea of multilingualism and generally encourages the dominant paradigm of Center English as the dominant international discourse, this researcher, through this research, aimed to promote if not multilingualism, at least linguistic flexibility.

2.3.2 Doctor-patient talk

Conventional doctor-patient talk is similar to conventional teacher-student talk with its components of initiation, response, and an evaluation of the response. For example, the teacher might ask a question (initiation), the student would answer the question (response), and the teacher would give oral feedback such as, “very good” (evaluation). In the case of doctor-patient talk, the doctor might ask a question (initiation), the patient would answer the question (response), and the doctor would make a suggestion, a diagnosis or write a prescription based on the patient’s answer (evaluation). While the teacher-centered classroom has lost ground in language education, replaced with constructivism and student-centered classrooms, and doctor-centered medicine is losing ground in liberal, Western countries, in many cultures both teacher-centered classrooms and doctor-centered medicine are still the norm (Ibrahim, 2001, p. 333).

It is important to understand that doctor-patient relationships are different in different cultures. In “Doctor and patient questions as a measure of doctor-centredness in
United Arab Emirates hospitals,” Ibrahim (2001) reported on a study that examined
doctor- and patient-centered medicine. Ibrahim suggested that rather than being bad, as a
Western perspective might assume, doctor-centeredness may just be a “different,” but
equally effective method of providing medical care (p. 342). In fact, where language
barriers exist in medical settings, the doctor-centered approach may prove advantageous
because it allows for formulaic exchanges that require less linguistic proficiency on the
part of both patients and health care professionals. Taking the position that open-ended
questions correspond to patient-centered medicine while close-ended questions
corresponded to doctor-centered medicine, Ibrahim found that attempts to be patient-
centered in medical settings in which more than one language and culture were
represented might not be effective. Besides the fact that language barriers might prevent
an understanding of the reply to an open-ended question, patients in Ibrahim’s study were
either frustrated by open-ended questions or inclined to answer “yes” or “no” rather than
supply the kind of descriptive answer that open-ended questions allow.

Gropper (1996) offered several possible interpretations of the reply “yes” in a
medical setting in which different languages and cultures were represented: “yes can
mean ‘I am listening but not promising or agreeing.’ ‘I do not understand what you are
saying, but I acknowledge you are trying to tell me something, and I am grateful for that’
is another possibility” (p. 2). Likewise, silence may indicate disagreement when a patient
is too polite to openly challenge anything a health care professional says.

Making health care professionals aware of potential cultural mismatches may be
more important than trying to impose some “culturally specific style of interaction”
(Ibrahim, 2001, p. 343) because no one style of interaction will be appropriate in every
environment and with every patient. While cultural awareness should be an integral part
of language courses for medical professionals, the environment that should receive the
most attention in such courses is the working environment.

2.3.3 ESP and real world work situations

Various authors have suggested conducting ESP courses as close to the workplace
as possible. Crandall (1984) suggested making the classroom into a simulated workplace
in order to integrate the language and the “specific purposes.” Other authors have taken
it one step further, suggesting that the best place for an ESP course is in the actual
workplace rather than a classroom, converted or not (Holliday, 1995; MacDonald et al.,
teaching does not disrupt the natural context of ESP courses in the same way a pedagogic
site does. Holliday (1995) added that on-site language training also allows it to be better
integrated into the work day.

The workplace context also helps keep the focus more on the specific purposes
and less on the language. As early as 1977, Allwright and Allwright were warning
against “the dangers of generalizing from one learning/teaching situation to another” (p.
58). A language teacher cannot assume that a curriculum designed for high school or
college language students who may not have any specific purpose for studying the
language will be appropriate for ESP students. Several researchers have emphasized that
the content of ESP courses should be relevant to the field of interest to avoid a mismatch
between what is learned in class and its usefulness in the workplace (DeBeaugrande,
Students in ESP courses should be prepared “for the realities, rather than merely the theories, of the workplace” (Mavor and Trayner, 2001, p. 355) while ESP instructors should be aware of the language demands faced by their students and target the specific linguistic challenges faced by the students in their specific context (Shi, et al., 2001; Svendsen & Krebs, 1984). However, focusing on linguistic needs may not be enough, as Widdowson (1981) pointed out twenty years ago. ESP courses should concentrate on issues of communication through use of a process-oriented approach in which learning how to learn is more important than learning how to produce specific linguistic forms. One significant problem stemming from goal-oriented approaches, as opposed to process-oriented approaches, is that learners may acquire adequate production abilities, but still be unable to actually communicate with their interlocutors. With the process-oriented approach “learning will continue beyond the completion of instruction since the aim of such instruction precisely is to develop the capacity to learn” (Widdowson, 1981, p. 6).

2.3.4 Meeting learners’ actual needs: From traditional language classes to specific-purposes classes

For practical reasons related to the traditional classroom context such as large class size, absence of a specific context, a focus on reading and writing skills, and the need to test and assess efficiently, many traditional language courses might not be appropriate for students who need language for specific purposes. In Bosher and Smalkoski’s (2002) study of international students using health care services at a U.S. university sixteen of eighteen participants report speaking and listening to be the most challenging part of their coursework and their interactions with patients. These recent
findings are consistent with Allwright and Allwright’s (1977) observations made over two decades ago that institutions “may be out of touch with the prospective students’ actual needs. They may even insist upon imagined rather than established needs” (p. 58).

In an article published in Issues in ESP on developing a hospital communication module, Fincham (1982) asserted that “the course should start from where the participants are and use their awareness of their communication problems” (p. 77). To set aside the perspective of the institution offering ESP courses and focus on the learners requires use of needs assessment. Svendsen and Krebs (1984) pointed out that “jobs vary greatly in the complexity of the language tasks workers must perform” (p. 160). This means that it might be mistake to assume that one ESP course for one group of medical professionals would be appropriate for another group of medical professionals. For example, nurses checking-in patients might be able to rely on a standard list of yes/no questions while practitioners might need more linguistic flexibility to get through an office visit. The possibility of such a wide variety of linguistics needs may make the prospect of needs assessment seem overwhelming, but according to Svendsen and Krebs (1984), “as one continues to observe, it becomes clear that language falls into fairly predictable patterns” (p. 160). The use of a case study, which includes extensive observation, might allow the researcher in this study to find predictable patterns that are useful in the design of an effective curriculum for languages for specific purposes.

The time spent in the field examining specific communication needs and their corresponding patterns during a qualitative case study allows the researcher to conduct a needs assessment. Case study “eliminates some of the danger of beginning from the
preconceived ideas an educator or researcher has about what ought to be difficult in a particular language context” (Schmidt, 1981, p. 208). Case studies also avoid reliance on learner intuitions by going beyond questionnaires to explore the language and culture needs of practicing professionals through prolonged observation and repeated, in-depth interviews. From the results of one case study, further quantitative tests might be designed to determine if the findings are generalizable to a wider population.

Shorter, less formal stays in the field offer many of the advantages of case studies without some of the disadvantages. In addition to ensuring that the ESP course matches the students’ true needs, time in the field can also aid the language teacher in becoming familiar with a new profession. After all, ESP teachers are more often than not language teachers who do not have any significant background in fields such as medicine, engineering, or business. It can be intimidating to teach a field-specific language course to practitioners well versed in that field. Svendsen and Krebs (1984) suggested that even “before concentrating on language itself, we need to acquire a thorough understanding of the specific job” the ESP student is to perform (pp. 154-155).

When teachers spend time in the field, they accomplish two things at once: gaining familiarity with the work of their students and discovering the communication difficulties confronted by their students. Obviously, such time is not available to conduct a needs assessment for each ESP course and certainly within one field on can learn from one’s own and others’ previous experiences in the field as well as the classroom. Other forms of needs assessment that can be conducted for each ESP course include
questionnaires and proficiency tests. According to Schmidt (1981), questionnaires reveal things course planners have not considered while proficiency tests reveal things students have not considered (p. 199).

2.4 Oral communication

Oral proficiency tests have become a common method of evaluating learner communicative competence. In order to understand what is meant by communicative competence and how it is important to this study, the following section explains the concept of communicative competence and its relevance to the present work. The discussion of communicative competence is followed by an examination of the two primary roles of language learners who engage in oral communication: speaker and listener. Oral proficiency has been widely studied and there is an abundance of speaking materials for both teachers and learners. The teaching and learning of listening, however, has not enjoyed such extensive attention, especially in the realm of practical pedagogical applications. The discussion of how listening “works” will be followed by an examination of strategy use, an important factor in both teaching and acquiring listening skills.

2.4.1 Communicative competence

The concept of communicative competence emerged as it became clear that grammatical competence alone was not enough for learners to approach native speaker knowledge of language. In the 1950’s the Foreign Service Institute (FSI) developed an oral proficiency rating scale because it needed it’s employees to function in target languages while working abroad (Bearden, 1998). In the 1960’s sociolinguists began
examining language as it was used in actual speech communities instead of focusing on the formal rules of language. This change in the field of linguistics contributed to the idea of communicative competence as “knowing how, when, and why to say what to whom” (Klee, 1998, p. 339). Starting in the early 1980’s communicative competence caught on in most academic settings in which languages were taught. Communicative competence aims to place language learners in authentic or near-authentic contexts in which they must be willing to take the risks inherent in expressing themselves in a foreign language and be resourceful in the use of vocabulary and structures to make themselves understood (Omaggio, 1986, p. 4). The goal of communicative competence is to “allow learners to use the target language in meaningful, interactive, and engaging ways” (Koike and Hinojosa, 1998, p. 33).

In addition to grammatical or linguistic competence, communicative competence is often said to include sociolinguistic competence, contextual competence, discourse competence and strategic competence (Omaggio, 1986). In the sociolinguistic sense, learners may have to use language to persuade, describe, narrate, or give commands. Communicative competence is context-specific, so language learners need to be prepared to communicate in different styles and registers. Discourse competence “is the ability to deal with the extended use of language in context…ordinarily achieved through the connection of a series of sentences or utterances to form a meaningful whole” (Alptekin, 2002, p. 58). Strategic competence involves the ability to use various strategies, such as circumlocution, and paralinguistic devices, such as gestures, intonation, and facial expressions to sustain communication.
Klee (1998) discussed another perspective on communicative competence in which it is said to be composed of linguistic knowledge, interaction skills, and cultural knowledge. The elements of this framework largely overlap with the one discussed above; however, Klee placed greater emphasis on the overarching importance of culture. She suggested that understanding cultural patterns in speech, the social stratification of speakers, contextual variation in conversation, and shifts in register are all important aspects of communicative competence. This means that it may not be enough to know how to persuade, describe, narrate or give commands in a second language without also knowing “the norms, values, and social structures of the society in which the language is spoken” (Klee, 1998, p. 342).

Klee (1998) also presented three communicative modes to consider when studying communicative competence. They are the interpersonal mode, the interpretive mode, and the presentational mode. The presentational mode refers to “one-way” productive communication, the interpretive mode refers to the receptive abilities to understand and interpret language, and the interpersonal mode “involves active negotiation of meaning” (p. 346).

The participants in this study used Spanish only in natural settings and had limited formal instruction. The processes through which the participants pursued communicative competence in Spanish, the communicative modes they actually used in the workplace, and the specific linguistic structures they acquired were examined through extensive observations and interviews.
2.4.2 Oral proficiency

Communicative language teaching often focuses on proficiency-oriented instruction in which students are provided with opportunities to actively and creatively use authentic language in a variety of contexts as they develop linguistic accuracy. In other words, the focus has moved away from what learners know about language and linguistic rules to how well learners can use the language in meaningful interaction (Grenfell, 2000; Lee, 2000; Omaggio, 1986; Turner, 1998). “Proficiency is seen as a superordinate goal that represents more than the sum total of all discrete items learned and that attempts to balance accuracy with fluency and learning about a language with providing the opportunity to learn a language by using it” (Heilenman and Kaplan, 1985, p. 59). For this reason, rating of oral proficiency skills is usually global and includes novice, intermediate, and advanced ranges with degrees within each range. A novice speaker might be able to repeat some learned words and expressions, but cannot use the language to communicate (Omaggio, 1986; Bearden, 1998). Basic communication is characteristic of intermediate speakers, who might be able do some basic creating with the language. Advanced speakers can perform daily activities in the target language, could function in a work setting in the target language, and could handle unexpected events. Progress slows as one advances from novice towards advanced. Table 2.1 shows oral proficiency rating scales (Omaggio, 1986, p. 13). These were developed based on empirical observations of actual language learners.
### Table 2.1 Oral proficiency rating scales

<table>
<thead>
<tr>
<th>Government (FSI) Scale</th>
<th>Academic (ACTFL/ETS) Scale</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Native</td>
<td>Able to speak like an educated native speaker</td>
</tr>
<tr>
<td>4+</td>
<td>Superior</td>
<td>Able to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+</td>
<td>Advanced Plus</td>
<td>Able to satisfy most work requirements and show some ability to communicate on concrete topics</td>
</tr>
<tr>
<td>2</td>
<td>Advanced</td>
<td>Able to satisfy routine social demands and limited work requirements</td>
</tr>
<tr>
<td>1+</td>
<td>Intermediate-High</td>
<td>Able to satisfy most survival needs and limited social demands</td>
</tr>
<tr>
<td>1</td>
<td>Intermediate-Mid</td>
<td>Able to satisfy some survival needs and some limited social demands</td>
</tr>
<tr>
<td></td>
<td>Intermediate-Low</td>
<td>Able to satisfy basic survival needs and minimum courtesy requirements</td>
</tr>
<tr>
<td>0+</td>
<td>Novice-High</td>
<td>Able to satisfy immediate needs with learned utterances</td>
</tr>
<tr>
<td>0</td>
<td>Novice-Mid</td>
<td>Able to operate in only a very limited capacity</td>
</tr>
<tr>
<td></td>
<td>Novice-Low</td>
<td>Unable to function in the spoken language</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>No ability whatsoever in the language</td>
</tr>
</tbody>
</table>

Kormos (1999) suggested that oral discourse competence should be characterized by the ability to “participate actively and appropriately” (p. 164) in conversations in the target language. For successful communication to occur, speakers must also display “supportive practices…such as priming topics and slowed speech” (Turner, 1998, p. 194) and be able to modify their speech based on listener signals (Shehadeh, 1999, p. 631).

For Kormos oral proficiency includes the ability to manage conversations by initiating, changing, and rejecting topics, holding and yielding the floor, and interrupting, as well as performing “openings, re-openings, closings and pre-closings” (p. 164). Kormos defined
conversation “as a face-to-face interaction which has not been planned ahead, and the outcome and sequence of which is unpredictable” (p. 165). Interlocutors share rights and duties in conversations, unlike interviews in which interviewers and interviewees have different rights and duties (p. 165).

While Kormos discussed the differences between conversations and interviews, VanPatten (1998) more generally categorized two basic purposes for communication. The first, which corresponds to Kormos’ conversation, is social-psychological and “involves the use of communication to establish, enhance, assure, or change social or psychological relationships between people” (p. 928). The second is cognitive-informational and it concerns “ask[ing] questions and process[ing] language in order to get information about a topic” for a specific purpose (p. 929). While the conversational, or social-psychological, purpose of communication is important for improving overall oral proficiency, the participants in this study often needed Spanish to conduct patient interviews and therefore were more concerned with the cognitive-informational purpose of communication.

The elements of proficiency may include functions, accuracy, and context; that is, the structures the learner controls, the accuracy with which the learner uses them and the contexts within which the learner is able to function. Vocabulary is considered an important function at the novice level because it is the base upon which other competencies develop (Bearden, 1998, p. 5).

In his study of Nepalese English learners who had either learned English exclusively through formal classroom education or exclusively through informal natural...
acquisition, Shresta (1998) concluded that vocabulary knowledge was more useful than grammar and structure knowledge for basic communicative purposes. The results of Shresta’s (1998) study indicated that both instruction and exposure aided second language acquisition. Formal education promoted accuracy while natural acquisition promoted fluency. It was Shresta’s conclusion that for communication purposes, “fluency seemed to be more critical than accuracy” (p. 231) because grammatical errors do not disrupt communication, but lack of fluency does. Shresta suggested that speakers in his study who focused on form experienced increased anxiety, which impeded fluency. Communicative language teaching is, in some sense, an attempt to reconcile the formal accuracy and informal fluency that Shresta observed in order to benefit from both.

The participants in the present study were more like the informal learners in Shresta’s study. Though most had some formal instruction in Spanish in high school, only two had undertaken any formal study while working in the clinic setting. Despite a lack of formal education, the participants all had regular contact with monolingual Spanish-speaking patients, which may have been an advantage for achievement in oral proficiency. In her study of college Spanish students’ oral skills, Lee (2000) found that “contact with native speakers either at home or in a foreign country may be an important factor in reaching higher levels of oral proficiency” (p. 134). However, Lee’s study also indicated disadvantages of informal contact without formal instruction. She found that “linguistic inaccuracy from informal training may keep speakers to lower levels of proficiency” (p. 136). Lee suggested that learners in a formal setting who have informal
training “should be more aware of the need to speak correctly to maintain a balance between function, content, and accuracy” (p. 136).

In addition to balancing the best elements of formal and informal language training, there has also been a call in the literature to seek a balance between oral production and other aspects of proficiency, particularly in the area of comprehensible input and comprehensible output. VanPatten (1998) asserted that in an attempt to align language teaching with communicative competence, proficiency guidelines were developed by the American Council on the Teaching of Foreign Languages for listening, reading, writing, speaking, and culture, but “testing mechanisms were developed and disseminated for only one: the oral skill” (p. 926). VanPatten argued that such an emphasis on oral production skills shifted the focus of communicative competence as a joint negotiation of meaning through various means to a focus on speaking and speakers. He further suggested that the focus of comprehensible input as the primary means of achieving oral proficiency might be misguided. He asserted that linguistic knowledge might result from actual use in which communication is attempted:

> It is not clear at all that linguistic analysis or knowledge of grammar necessarily—if at all—precedes use. What seems more reasonable is that the internalization of grammar and language is a result of the ongoing process of communication. To state this another way, the interpretation, expression and negotiation of meaning may precede and actually cause language acquisition (p. 928).

Other scholars have agreed with VanPatten (Grove, 1999; Shehaden, 1999; Vandergrift, 1997) and a model of comprehensible output has emerged to complement Krashen’s comprehensible input model. It is argued that through speaking, learners gain the opportunity to test their own linguistic hypothesis (Grove, 1999, p. 819). This
comprehensible output makes learners aware of what they do and do not know as they “receive feedback from their interlocutor about the comprehensibility of their utterances” (Vandergrift, 1997, p. 495). Swain first proposed the concept of comprehensible output. She specifically suggested that comprehensible output allowed learners to shift from a focus on semantic analysis to a focus on syntactic analysis as they use the target language. Such a shift in focus allows learners to consciously reflect on their language in use and consequently notice gaps in their knowledge (Shehadeh, 1999, p. 630).

Although Grove (1999) emphasized that the output hypothesis was designed to complement the input hypothesis by including output as “an important causal variable in second language acquisition” (p. 819), he argued that the model of a linear progression from input, through intake to output is erroneous. According to Grove, the comprehensible input model alone would have speaking emerge “as a result or outcome of successful L2 acquisition, rather than contributing directly to the acquisition process” (p. 818). Throughout the literature compelling arguments are made for the importance of both input and output in the negotiation of meaning as “both learners and their interlocutors work together to produce comprehensible input and comprehensible output” (Shehadeh, 1999, p. 631). While the existing literature advocating both the comprehensible input model of language acquisition and the comprehensible input and comprehensible output model is relevant to the medical setting in which this study was conducted, there is a unique issue in the present research that is not addressed in the literature. That is the situation in which comprehensible output has been achieved, but comprehensible input remains elusive.
2.4.3 The listening component of second language acquisition

For professionals who need language skills to communicate orally with clients and colleagues, needs assessments focus on speaking and listening skills. Within a field, the teaching of speaking skills might focus on the production of specific vocabulary and expressions. Listening, however, is less predictable in that instruction cannot focus on understanding certain spoken words and expressions since listeners cannot know or control the content of what they hear. For this reason this section will explore the literature on the listening aspects of language acquisition in an attempt to understand how one might approach the teaching of listening in a language course for specific purposes.

In the 1980’s researchers agreed that “learners need to notice and interact with linguistic input in order to acquire the target language” (Chapelle, 2001, p. 19). It was in the 1980’s that Krashen’s comprehensible input model came to prominence (Krashen, 1985). Foreign and second language teachers learned the mantra of (i+1)—in order to gain linguistic proficiency students need input slightly above their current proficiency level. Recent theorists (Mendelsohn, 1998; Rost, 1990) have called attention to the central importance of active listening, asserting that it is not enough to receive input. Listening is regarded as an active, conscious process of interpreting, not just decoding. The active listener draws inferences as well as decodes the message and as such \textit{constructs} meaning. Listening is seen as one element in a “collaborative process” (Rost, 1990, p. 3).
Within such a framework, the prominence of listening in language acquisition becomes clear because it is the “primary channel by which the learner gains access to L2 ‘data’ and…it therefore serves as the trigger for acquisition” (Rost, 2001, p. 8). Rost (2001) asserted that listening is the most widely used language skill. Certainly at a time in history when technology and globalization have accelerated the need for oral communication skills, the importance of listening cannot be overlooked. If listening is one of the most important language skills, it is also one of the most problematic. Unlike readers or speakers, listeners cannot directly control the pace or the content of the incoming information. As one researcher put it, listeners “are at the mercy of speakers. Listeners have almost no control over what is going to be said, how it is going to be said, and how quickly it is going to be said” (Mendelsohn, 1995, p. 132). Listening may also be the most mentally taxing skill (Brown, 1995; Rubin, 1995) in that processing listening puts demands on short-term and working memory such “that less is available for coping with the cognitive demands of the task” (Brown, 1995, p. 69). To further complicate matters, language learners cannot adopt a single listener role.

Rost (1990) identified four possible listener roles: participant, addressee, auditor, and overhearer (p. 5). Throughout this study, the focus will be more on interactional listening than transactional listening. While academic settings often require the one-way communication used to convey information and ideas that is characterized by transactional listening, most real-world listening tasks are interactive. Real-world linguistic exchanges tend to always be embedded in their various social, professional, and academic settings (Rost, 2001, p. 8). Considering the context within which one is
communicating can provide helpful clues as to the content of the message one is trying to interpret. As is discussed at length below, access to background knowledge related to particular contexts allows for inferencing, interpreting, and editing, which improve listening comprehension (Rubin, 1994, p. 209). It also taps the “active and creative dimensions of listening” (Richards, 1985, p. 192).

2.4.3.1 Listening: A description

Though it may appear that not a lot is known about the process of listening, some clear findings have been made in the field. Listening is not a linear, sequential process; rather, it is recursive. It involves simultaneous bottom-up and top-down processes at phonological, grammatical, lexical and propositional levels (Rost, 2001, p. 7); however, the issue of distribution of top-down and bottom-up processes has not been clarified. “There is an ongoing discussion in L2 research as to whether listeners use their knowledge of the world, situations, and roles of human interaction to focus on meaning (top-down) and then use their knowledge of words, syntax, and grammar to work on form (bottom-up) or vice versa, and as to when and how these two interact (i.e., when and how does parallel processing take place)” (Rubin, 1994, p. 21). Rubin identified five factors that affect listening: text characteristics, interlocutor characteristics, task characteristics, listener characteristics, and process characteristics. Process characteristics include the nature of the interaction between the speaker and the listener as well as the listener’s cognitive activity (Mendelsohn, 1998, p. 82).

Listening is thought to be more than a matter of processing linguistic data. Authentic, real-life listening, used as “a functional mode of communication” (Rost, 1990,
p. 28) focuses on meaning, not on form. Successful listening also involves ‘interactional work’ such as making obligatory responses, initiating, repairing communication problems, knowing when maxims of cooperation are deliberately ignored (irony, metaphor), providing appropriate feedback, and identifying such things as topic shifts, speaker’s intention towards hearer, ambiguity, contradiction, lack of sufficient information, fact versus opinion, and changes in pitch, tempo, and pause (Rost, 1990, p. 115; Rost, 2001, p. 10).

As the models of language teaching have changed, the importance of input has also undergone changes. With the behaviorist model, input was considered the major factor in listening since proficiency was perceived to be a matter of successful imitation. It has since become clear that L2 learners create a system (Gass, 2000, p. 32) and the view of input has evolved accordingly. Krashen’s comprehensible input model also allows for a distinction between input and intake. Input is the target language available to learners, while intake is the language comprehended, incorporated and used by the learner (Brown, 1985; Gass, 2000).

The comprehensibility of increasingly challenging input is a necessary, but not sufficient condition for second language acquisition (Gass, 2000; Rost, 1990). Emphasizing the centrality of the learner, Rost and Ross (1991) pointed out the importance of active, willful interaction: “it is the learner who must come to understand the target language through conscious decisions to understand target-language speakers and to engage in interactions in the target language in which meaning of some import is at stake” (p. 236). Once learners are willfully engaged in soliciting input and turning it
into intake, the issue of how the process of listening and understanding proceeds still remains open. “Learners must focus their attention on and isolate some portion of the input. Once the input is noticed, learners have to determine what patterns are present” (Gass, 2000, p. 31). Determining the patterns present in speech is not a simple task. At the very least it involves segmenting speech into meaningful units, organizing it into syntactic units, and forming hypotheses about grammar.

One of the central issues in listening research is the segmenting of speech. This is one of the primary differences between incoming speech in listening and incoming text in reading. With listening “the phonetic units of speech are represented in continuous, overlapping segments of the signal and there is no agreed-upon mapping from acoustic information to identification of phones or phonemes” (Danks & End, 1987, p. 273). What is clear is that listeners must learn to negotiate medium factors that are not obstacles with other sources of language input, namely reading. Listeners must negotiate speech based on clauses while writing is based on sentences. Reduced forms (also called sandhi) such as slurring, dropping, assimilation, mutation, contraction, and elision may interfere with the listening process. Speech is much more likely than writing to contain ungrammatical forms and issues such as empty or filled pausing, rate of delivery—which is really the duration, distribution and frequency of pausing, hesitation—such as repeats, false starts, rhythm, and stress are all controlled by the speaker (Richards, 1985; Rubin, 1994). In addition to the listener’s inability to control speech rate, he or she also “has no continuing access to it” (Danks & End, 1987, p. 273). Danks and End (1987) described the predicament of the listener in the following way: “listeners receive a continuous signal
over which they have very little control. They are forced to process the signal immediately regardless of whether they are prepared to receive new information or whether they are still processing the immediately preceding signal” (Danks & End, 1987, p. 273).

However, there are elements of oral language that work to the listener’s advantage in segmenting speech. Danks and End (1987) expressed the traditional view that “speech contains prosodic cues that provide valuable information to listeners about how to segment syntactic constituents such as phrases and clauses” (p. 273). Unlike prepared written texts, oral language is spontaneously prepared for a specific audience, in a given context, in a unique time and place. Horowitz and Samuels (1987) offered a more flexible view, suggesting that for the listener, “cohesion is expressed through deixis (references to items outside of a discourse or text),…through prosodic cues (the pitch, stress, and pauses expressed by the language) and paralinguistic devices (such as facial expressions, lifts of the eyebrow, smiles or frowns, or body language such as pointing or distancing oneself from a listener)” (p. 7). Horowitz and Samuels claimed that much of the message is conveyed not through words, but through a variety of nonverbal cues and interlocutor relationships. Thus, the advantages enjoyed by listeners over readers range from visual and audio clues to paralinguistic and extralinguistic cues. Menedelsohn (1998) asserted that “there is no question that a listener’s access to visual clues as well as audio clues assist comprehension considerably” (p. 88) and Rubin (1994) cited studies that further support Menedelsohn’s assertions. Menedelsohn (1998) advocated using video in the teaching of listening because listeners in foreign/second language classes “should
have access to at least as many signals—linguistic, paralinguistic, extralinguistic—as the native speaker does in real situations” (p. 88).

Another important medium difference between listening and reading, namely its interactive nature, may work to the listener’s advantage. Recent research has acknowledged “reciprocity between interlocutors…with the audience functioning as ‘co-author’” (Horowitz & Samuels, 1987, p. 5). With listening, “meanings are constructed cooperatively” (Richards, 1985, p. 196) so conversation is organized through mutual cooperation in progress and is not planned like writing. Rubin (1994) cited studies that point to redundancy in input and morphological and syntactic modifications as aiding a listener’s comprehension and oral language is full of redundancy, restatement, repetition, and other types of emphasis.

According to Richards (1985), this processing of speech at the linguistic level is a different sort of processing than the discourse processing that he divides into three levels: propositional identification, interpretation of illocutionary force, and activation of real-world knowledge. Propositions are basic units of meaning involved in comprehension; the listener tries to determine the propositions he or she hears in order to chunk incoming discourse. Propositional segmenting differs from the grammatical segmenting mentioned above in that propositional meaning is stored in long-term memory. Grammatical competence, which includes things like syntactic knowledge of the target language, is purely abstract. Real world knowledge enters at the level of propositional identification. This is what allows a listener to comprehend a semantically illogical proposition—pragmatics lends interpretive meaning at the propositional level.
The second level of discourse processing is interpretation of illocutionary force, which is the speaker’s intention. Richards (1985) relied on speech act theory and the relationship between form and function in social interaction. In speech act theory, speech is a social tool and listeners have to use knowledge of a given situation to interpret speech. People generally follow rules of conversation as manifested in Grice’s cooperative principle with its maxims of quality, quantity, relation and manner.

The third level of discourse processing, activation of real world knowledge, can be understood best through an examination of cognitive theory. In the cognitive theory of language learning, learners are central to the entire process. They are active makers of meaning and “meaning is constructed through a complex interaction between the characteristics of the input, the types of declarative knowledge that are accessed, and the use of strategic processes to enhance understanding” (Chamot, 1995, p. 16). Background knowledge is central to cognitive theory because learners must integrate new information with prior knowledge and then use that knowledge appropriately.

In cognitive theory, incoming information is briefly stored in short-term memory. Information moves from short-term memory to the working memory. From the working memory, information is either lost or incorporated into background knowledge in the form of schemata. Each schema can be visualized as a web of related information or a file drawer with all the files pertinent to that schema stored in it. The information stored in the file drawer has been successfully retained in long-term memory. Both declarative knowledge, what one knows, and procedural knowledge, what one knows how to do, are stored in long-term memory (Chamot and O’Malley, 1994).
According to Rost (1990) four key notions of schema theory exist: concept abstraction, which amounts to the hierarchy of schemata arrangement; instantiation, in which new information is integrated into existing schemata during interpretation; prediction, or filling in blanks; and induction, in which previous experiences with a generic concept allow for new related schemata to be formed (Rost, 1990, pp. 19-20).

Chamot and O’Malley (1994) described four contributions of the cognitive view to second language learning. First, it “describe[s] the flexible and adaptive nature of language processing.” The cognitive view also shows “how knowledge and complex mental skills such as a second language can be learned, stored in memory and juxtaposed relative to native language knowledge and skills.” Because the cognitive view provides a model of mental processing, it accounts for the role of learning strategies and therefore has direct implications for explicit strategy instruction (1994, p. 380). The first two contributions to second language learning are abstract, but the third and fourth contributions have direct implications for second language learning and teaching.

Cognitive learning theory indeed offers some contributions to the field of second language acquisition because it implies that teachers and learners can actively examine language learning and improve upon it. Learners can be made aware of their own cognitive processes and develop strategies to successfully activate schemata and incorporate new information into long-term memory. Teachers can help students deploy background knowledge and integrate new knowledge. These ideas are developed further in the following section on strategies, where specific implications of cognitive learning theory for listening are delineated.
2.4.4 Internal factor: Strategies

Oxford (2001) defined learning strategies as “operations employed by the learner to aid the acquisition, storage, retrieval and use of information, specific actions taken by the learner to make learning easier, faster, more enjoyable, more self-directed, more effective and more transferable to new situations” (p. 166). The possible characteristics of strategies are wide-ranging. They can take the form of general approaches or specific actions. They can be linguistic as well as non-linguistic. They can be observable behavioral strategies or non-observable mental strategies (Ellis, 1994). Strategies vary depending on the learner, the task, and the goals. If the goal is to communicate in a natural setting, for example, the strategies employed are different than if the learner’s goal is to get a good grade in a class (Oxford, 2001).

From a cognitive learning perspective, strategies are important because they both promote learner autonomy and help learners to link new information with existing schemata instead of learning by rote memorization. Through repeated application, strategy use can become automatic thus easing “the burden on short-term memory, which can then focus on the meaning of the incoming language” (Chamot and O’Malley, 1994, pp. 378-379). This view empowers both teachers and learners to actively participate in improving language acquisition. It also promotes ongoing learning beyond the classroom setting (Oxford and Nyikos, 1989). The idea that strategy instruction is about learning to learn is important to this study in two ways. First, working professionals may need short-
term help with linguistic and cultural phenomena, as might be provided by a language course, that they can use in the work place over the long term. Teaching learners to apply a few strategies when confronted with a variety of listening tasks might be an appropriate solution. Second, because listeners cannot control the content of what they hear, strategies for improving listening that can be applied to various situations might better equip learners for the workplace context than an attempt to train learners to understand fixed expressions.

A number of scholars who have written about strategies have developed taxonomies. Ellis (1994) wrote about how strategies are studied, providing historical information on early classification systems. He then differentiated three types of strategies: production strategies, which the learner uses in attempting to employ language efficiently and clearly; communication strategies, which the learner uses to deal with problems that arise during interaction; and learning strategies, which the learner uses to develop linguistic and sociolinguistic competence. Rost and Ross (1991) examined global, local and inferential strategies while Chamot and O’Malley (1994) distinguished between communication strategies, used to negotiate meaning in conversation, and learner and learning strategies, used to facilitate learning. According to Chamot and O’Malley, learner strategies are those strategies developed by learners while learning strategies can be taught explicitly, typically by teachers and tutors.

With cognitive learning theory, the taxonomies have narrowed to the point that scholars discuss metacognitive, cognitive, social and affective, and compensatory strategies (Chamot, 1995; Chamot and O’Malley, 1994; Mendelsohn, 1998; Oxford 2001;
Oxford and Nyikos, 1989; Rubin, 1994). Metacognitive knowledge is at the forefront, allowing access to other levels of cognition and guiding other processes and strategy use. Metacognition deals with one’s knowledge of one’s learning processes, including strategy use. Metacognitive strategies are those concerned with planning, administering, and evaluating learning processes (Ellis, 1994; Mendelsohn, 1998; Oxford and Nyikos, 1989). According to Chamot and O’Malley (1994), language learning effectiveness is largely determined by “explicit metacognitive knowledge about task characteristics and appropriate strategies for task solutions” (p. 382). Chamot and O’Malley’s (1994) list of metacognitive strategies includes directed attention, selective attention, advanced organization, organization planning, self-management, self-monitoring, and self-evaluation.

Cognitive strategies are those used to integrate new information with existing schemata. At their most basic, cognitive strategies are used to facilitate storage and retrieval of information (Rubin, 1994). Examples of cognitive strategies include guessing, reasoning, hypothesis testing (Oxford, 2001), instantiating prior knowledge, making inferences, summarizing, grouping, and using linguistic transfer, imagery, and auditory representation (Chamot and O’Malley, 1994).

Social strategies involve working with others to achieve mutual comprehension while affective strategies refer to feelings, such as anxiety, and attitudes as well as being aware of their instigation and prevention. Compensatory strategies, such as circumlocution, are used to make up for gaps in knowledge.
Early studies of learning strategies focused on good language learners versus bad language learners and concluded that good learners use more strategies, use them better, use them more often, and are more able to talk about them (Chamot and O’Malley, 1994; Ellis, 1994). While less effective learners seem to have default strategies that they employee without consideration of the given task, “strategic learners are able to regulate their own approach to a task, choosing and changing strategies depending on their goals, the nature of the task, and their metacognitive knowledge about their own learning processes” (Chamot, 1995, p. 15). Good language learner studies also found that strategy use depended on learner proficiency, or stage of L2 development. Lower proficiency learners use more compensatory strategies that higher proficiency learners do not need (Rost and Ross, 1991). According to Mendelsohn (1998), advanced learners are more able to successfully use metacognitive strategies. Good strategic learners are more equipped for learning; that is, they have better metacognitive control and are thus more likely to become advanced learners. Learners can improve their language learning, then, by becoming aware of strategies and their effectiveness (Mendelsohn, 1998).

Though it is assumed that strategies influence the rate of acquisition and the ultimate level of achievement, many scholars agree that a multitude of factors must influence strategy use. Oxford (2001) mentioned motivation, learning environment, learning style, personality, gender, culture, national origin, career orientation, age, and language task as influencing factors. Ellis (1994), however, cautioned that weak links exist between strategy use and affective states, language aptitude, learning style, and personality type. Oxford and Nyikos (1989) reported on a study of university students
that suggests that learners adjust strategies according to their circumstances. Because of
the classroom setting students disregarded independent, metacognitive, and functional
practice strategies in favor of general study strategies and formal rule-related practice to
succeed on tests. This lends insight into the importance of aligning strategy instruction,
as well as all other aspects of instruction, with the ultimate goals of the course.

2.4.4.1 Strategy use and listening

Mendelsohn (1995) proposed two layers of strategy development for listeners:
recognition of speaker signals and use of signals to predict, guess, and infer (p. 134). In
other words, a technical aspect of linguistic decoding complements an abstract aspect of
making meaning with the linguistic information available. The research and literature
mostly focuses on strategies having to do with the latter aspect of strategy development,
though Rost (2001) briefly mentioned that strategy instruction in linguistic decoding must
address the phonological system, possible sound sequences, tone melodies and the stress
system (p. 9).

The early sources of information on listening strategies came from studies that
compared good and bad learners. Chamot and O’Malley (1994) reported on a listening
strategy study in which clear differences in strategy use between effective and ineffective
listeners were apparent. “Effective listeners used comprehension monitoring, association
of new information to prior knowledge, and making inferences about unknown words or
information” (p. 381). Ineffective listeners tried to parse meaning on a word-by-word
basis, violating the importance of listening for meaning instead of listening for language
practice (Rost, 2001, p. 11). Ineffective listeners did not apply schemata, use elaboration,
or attempt to infer meanings.

According to the studies cited by Rost (2001) and Rubin (1994), the differences
between effective and ineffective listeners were manifested at the level of metacognitive
strategies. Metacognitive strategies involve the listener’s choice of strategies that allow
for planning, monitoring and evaluating comprehension. This metacognitive knowledge
allows for strategy use according to the varying characteristics of the text (Rubin, 1994,
p. 211). Good listeners have to recognize communicative difficulties and actively use
strategies “to change instances of non-understanding and misunderstanding into
acceptable understanding” (Rost, 1990, p. 154). This study examines the listening
strategies used by the participants in order to determine whether they are effective
listeners and to promote effective listening through development of specific strategies.

Rost (2001) offered several specific strategies for improving listening
comprehension. In general, comprehension can be improved by training in hypothesis
testing (asking about specific information) as an alternative to ‘lexical pushdowns’
(questions about meaning) and ‘global reprises’ (requests for general repetition) (p. 11).
The listener can specifically work to identify speaker intent, be aware of power
asymmetries, provide obligatory responses, provide prompts to the speaker to continue,
provide cues as to how the listener aligns with the speaker, be able to reformulate the
speaker’s contributions, and determine points in the conversation at which the listener
can transition to the speaker role.
Metacognition is important in the successful deployment of listening strategies because listeners should aim to integrate what they hear with existing schemata while the discourse is in progress. This not only requires a large quantity of possible strategies, but knowledge of how and when to use them. According to Rost (1990), successful listeners have to deploy listening strategies flexibly, move away from high-risk strategies (such as assuming understanding) to low-risk strategies (such as checking understanding), tolerate ambiguity, identify sources of non-understanding, and sort out important information. All of this is aided by a perspective in which the goal of listening is collaboration with a speaker, not a lonely task for the listener to undertake (Rost, 1990, p. 157).

A discussion of the literature on listening cannot conclude without mention of negotiation. Pica (1994) defined negotiation as “the modification and restructuring of interaction that occurs when learners and their interlocutors anticipate, perceive, or experience difficulties in message comprehensibility” (p. 494). Often speakers will vary their language to accommodate language learners, but negotiation between the speaker and listener facilitates comprehension more than speaker modification alone (Rubin, 1994, p. 215). Instead of the speaker attempting to determine where the listener is encountering difficulties, negotiation allows for the listener to issue a specific request for clarification or confirmation through open-ended questions or requests for confirmation. The speaker can then modify what was said through repetition, elaboration, simplification, or some other modification of the message (Gass, 2000; Pica, 1994). By involving both parties, negotiation forces the learner’s attention on problematic aspects of communication and, Pica (1994) suggested, provides an opportunity for comprehension.
Having said so much in favor of negotiation, Pica (1994) also offered some caveats. Negotiation may be successful in learning vocabulary and large syntactic units that the learner is ready to internalize, but negotiation does not aid in learning grammar. Negotiation may result in non target-like forms and too much negotiation may harm social interaction.

At the beginning of this study, in an attempt to trigger metacognitive awareness, participants were asked to think about and articulate the strategies that they used to communicate with Spanish-speaking patients. Throughout the study new strategies, such as those discussed above, were suggested by the researcher in an attempt to increase both metacognitive awareness and the number of possible strategies to choose from in their attempts to collaborate with the speakers of Spanish they encountered in the workplace.

### 2.4.4.2 Strategy-based approaches to teaching listening

Mendelsohn (1995) claimed that good language learners use various strategies and that strategies can be learned (pp. 134-135). A strategy-based approach to teaching listening, then, would help learners to be conscious of listening as well as teach students how to learn and therefore work more independently.

Rost and Ross (1991) proposed two perspectives on strategy instruction. According to the proficiency position, proficient learners can chunk input and turn it into intake in the course of a conversation so strategy attention can go to metacognitive strategies while less proficient learners need to use compensatory strategies such as pushdowns. On the other hand, the context position suggests that all learners always have access to all strategy types and their use depends on task type, text type, and setting.
The context position would involve instruction in all strategies at all levels. Rost and Ross (1991) proposed a compromise between the proficiency position and the context position. “The context position must be tempered by cognitive considerations: the type and amount of text information to be understood will influence the strategies that a listener can enact. The proficiency position must be tempered as well by the overriding pragmatic principles in comprehension. Comprehension is context-dependent” (p. 265).

In a real world setting such as the perinatal clinics in which this study took place, the compromise proposed by Ross (1991) naturally manifests itself. Because the setting was limited to a perinatal medical context, the tasks, texts, and settings did not vary much and therefore allowed for the attempted use of various strategies. However, since the participants in this study were the most proficient health care professionals in the setting, metacognitive strategies were frequently discussed and employed throughout the study.

According to Ellis (1994), little research has been done on strategy training; however, several other scholars claimed a positive correlation between strategy instruction and successful language learning (Chamot, 1995; Chamot and O’Malley, 1994; Mendelsohn, 1998). Chamot and O’Malley (1994) suggested that, in general, studies show that explicit strategy instruction improves language learning. Citing Thompson and Rubin’s longitudinal study of students of Russian that showed that learners can be taught to use different and more effective strategies, Mendelsohn concluded that “strategy instruction can improve listening comprehension” (Mendelsohn, 1998, p. 83).
While it has long been clear that simply providing input that is sometimes followed by feedback or comprehension questions is not a sufficient condition for listening comprehension, cognitive learning theory highlights the importance of constantly using many and varied strategies so that students learn how to listen. The advantage of this approach is that “learning strategies are readily teachable” (Oxford and Nyikos, 1989, p. 291) so teachers can be explicit in strategy instruction.

According to Mendelsohn (1998), intrinsic cognitive difficulty of listening text--characterized by the clarity of spatial relations and chronology, number of and differences among characters, amount of inferencing required, and consistency with the listener’s background knowledge--matters more than grammar and vocabulary when it comes to comprehension. By extension, this means that activating appropriate schemata is more important than providing vocabulary and grammar. Chamot and O’Malley (1994) emphasized the importance of scaffolded instruction in the form of describing, modeling, practicing, and eliciting discussions of strategies until strategy instigation can be done independently and automatically. Taken together, the literature demonstrates that nothing alone is sufficient to teach listening comprehension. Therefore, in the present study the researcher offered strategies to participants, encouraged their use as suggested by Chamot and O’Malley (1994), and elicited feedback from participants as to the effectiveness of the strategies used. When possible, the suggestions for strategy instruction that follow were used in this study; however, because this was a descriptive study without any formal instructional component, the suggestions below are more relevant to the implications for curriculum design that are discussed in chapter five.
It is clear that learners need to think about what they are listening for before guided activities, use real data, and do something with what has been comprehended so that they learn how to listen. Likewise it is clear that strategy instruction should be explicit, authentic, relevant, and integrated with regular instruction (Mendelsohn, 1998; Oxford, 2001). While this is far from the popular wisdom that listening is just a matter of exposure and that comprehension will result from non-specific input, the fact that listening cannot be broken down into a step-by-step taxonomy still makes strategy instruction in listening somewhat problematic. Mendelsohn (1998) offered some provisional guidelines to aid in providing coherent listening instruction. First, listening materials must be carefully chosen according to level, appropriateness, relevance, authenticity, and ease of administration. Instruction must include work on strategies to determine such things as genre, main idea, setting, interpersonal relations, mood, topic, and meaning. Students should practice predicting, hypothesizing and modifying hypotheses when guesses are wrong. Far from “cheating,” use of paralinguistic and extralinguistic signals is authentic. Once students have been guided through the strategies they should be given authentic, unguided listening which aims for overall comprehension (Mendelsohn, 1995, p. 138).

All of these micro-strategies must be guided by metacognitive awareness on the part of the listener. Listeners have to be confident in their ability to know when to use which strategies and how they might affect learning outcomes. Ultimately, listeners should be able to automatically deploy automatized strategies for routine listening tasks (Chamot and O’Malley, 1994).
Samuels (1987) offered a framework for oral communication that, if used for explicit instruction, might facilitate oral communication between two people who do not share a native language. His framework consists of inside-the-head factors and outside-the-head factors. For the purposes of this study, inside-the-head factors such as language facility, background knowledge, speech registers, metacognitive strategies, kinesics, and motivation may be used to both describe and explicitly teach listening skills. Likewise, outside-the-head factors like speaker awareness of audience need, clarity, and provision of context may be used to address the speaking aspect of oral communication.

2.5 Conclusion

Communicative competence is at the heart of any study of oral communication in a natural setting, particularly one in which second languages are used. Oral proficiency and listening go hand-in-hand in a setting in which native English-speaking health care professionals attempt to communicate with native Spanish-speaking patients. Listening is clearly an important element in second language acquisition since it is the primary source of L2 data for most learners, but one over which the listener rarely has control. Strategy use appears to influence successful learners and explicit instruction in strategy use appears to improve language learning. Taking all of this into consideration, one lingering question related to this study remains. What about language learners who have learned, as opposed to acquired, all the oral proficiency they need to produce, but appear to lack listening skills? This goes against the supposition so often asserted in this chapter that there is an “apparent causal relationship between intake of spoken language and
language acquisition (that is, understanding language appears to be a necessary condition for acquiring language)” (Rost, 1990, pp. 27-28).

While it is often asserted that input is not enough for second language acquisition because interaction is also important, the assumption is that acquisition means production. Comprehension is seen as a prerequisite to production. Yet in the case of the health care professionals who were the subject of this study, production preceded any kind of processing of intake. Pica (1994) emphasized the importance of both comprehension and production, but suggested that comprehension preceded production in a kind of sequential, cause-and-effect manner (p. 501). This study focuses on those learners for whom such a cause-and-effect pattern does not exist because production has preceded comprehension.

Having now considered the literature in the fields of Spanish for Specific Purposes, English for Specific Purposes, and communicative competence as it relates to second language acquisition, the focus turns to a specific project which consists of a qualitative case study of English-speaking health care professionals who need Spanish to communicate with their Spanish-speaking clients.
CHAPTER 3

METHODOLOGY

3.1 Introduction

For this research a qualitative case study was used to provide an in depth description of the communicative needs of health care professionals working with Spanish-speaking clients in perinatal clinics. The insights of the participants along with the researcher’s observations and analyses of documents helped form an understanding of what elements would be useful in Spanish language and culture curricula for health care professionals. The participants were a representative sample of the health care professionals working in the clinics. During data collection, the data were managed using NUD*IST software. After the data collection was completed, the data were coded, triangulated, and analyzed following the premises of grounded theory. Participants were consulted on early drafts of portions of the study pertaining to them. In this way, member checks formed another part of the data analysis procedure.

The details of the methodological procedures follow, beginning with a description of sampling and sampling procedures. Paradigmatic and methodological assumptions are described and justified. A discussion of data gathering techniques and trustworthiness and
ethical issues is followed by a description of data analysis procedures. Finally, the chapter concludes with a description of the pilot study.

3.2 Population and sample

The population of interest for this study is English-speaking practicing health care professionals who have Spanish-speaking clients. The participants are health care professionals in a system of three perinatal clinics run by the health department in a large city in the Midwest part of the United States where approximately twenty-five to fifty percent of patients in these clinics are Spanish-speaking.

The clinics provide prenatal care to expectant mothers and therefore deal with a limited range of services, which allows the scope of the study to be narrowed to health care professionals’ communication with Spanish-speaking clients within the context of perinatal care only. Besides limiting the scope of medical issues, the clinics also provides a predictable, tranquil environment compared to the surroundings of other health-care settings in which language barriers exists, such as hospital emergency rooms. This aligns with Patton’s (1990) description of purposeful sampling in qualitative studies, where relatively small samples are selected for in-depth study. The purpose is to seek information-rich cases “from which one can learn a great deal about issues of central importance to the purpose of the research” (Patton, 1990, p. 169). A more hectic health care environment or one with more diverse health care issues might make it harder to get at the issues of communication that are central to this study. In the first place, the relatively tranquil environment allowed for researcher presence that is useful—when the researcher acts as interpreter—rather than disruptive. The reliable hours of clinic
operations provided the opportunity to schedule off-hour interviews in advance without unduly burdening the participants’ free time. The limited health care issues in a perinatal clinic provided a focus for the study of language since similar vocabulary and expressions were likely to be used over and over by both patients and health care professionals. This narrowed scope allowed for measured tracking of participants’ progress in speaking and listening.

This ethnographic study began with participant observation, which combines systematic observation with membership in the community being observed so that the data is informed by both the formal research of the outsider and the life experiences of the insider. By volunteering as an interpreter during working hours for seven weeks the researcher contributed to the environment from which she extracted her data and actively participated in clinic operations ranging from observations in the public lobby to witnessing interactions between clients and health care professionals. Through both routine interactions and informal interviews that occurred during the twenty hours a week spent in the clinics during the study, the researcher was able to identify a range of Spanish linguistic and cultural skills needed by the various health care professionals working in these clinics.

Snowball or chain sampling was used to select interviewees for interviews. Patton (1990) described this sampling procedure as follows: “the chain of recommended informants will typically diverge initially as many possible sources are recommended, then converge as a few key names get mentioned over and over” (p. 176). In this way the researcher first sought interviewees who had acquired some level of Spanish on the job.
Following Erickson’s (1986) admonition that “a deliberate search for disconfirming evidence is essential to the process of inquiry” (p. 147), the researcher also sought disconfirming cases. For the purposes of this study, snowball sampling will lead to confirming cases (those who express an interest in learning Spanish and have succeeded, to some degree, at on-the-job speaking) as well as “examples that don’t fit” (Patton, 1990, p. 178) (those professionals who are either not trying or not succeeding with on-the-job speaking). The representative group of health care professionals chosen for this study included three nurses, one nurse midwife, and a nutritionist. These were the medical professionals who had the most frequent and direct contact with Spanish-speaking patients and had the greatest interest and need for communication skills.

3.3 Setting

Each of the three clinics is located in a different low-income area of the city. Often the clinics are referred to as “north” or “west” rather than the official name of the clinic or the name of neighborhood in which they are located. The clinics are operated by the health department and all are light-filled spaces with fresh, pastel paint on the walls.

The main entrance of each clinic leads to the lobby. Folding chairs are set up around the perimeter of the lobby for patients to sit in while waiting for their appointments. End tables hold worn past issues of pregnancy and parenting magazines as well as some children’s books. A cart with a television and VCR often stands in the corner of the lobby with informational videos about pregnancy and parenting playing.
More patients and longer delays increase the likelihood of the television being in use. Occasionally children’s videos are showing for the older siblings waiting in the lobby with their mothers.

A counter at one end of the lobby divides the waiting area from the reception desk. Next to the counter is a door that leads back to the exam rooms. Each reception area had a leafy water plant with the roots growing down into a fish bowl with a beta fish swimming in it, but the fish-bowl vases have been moved to areas more suitable to the survival of the plant and the fish in two of the clinics. Upon arrival, patients sign in on a yellow sheet of paper on a dark wooden clipboard. The reception area displays the organized clutter that is apparent in most medical settings: manila folders with colorful tabs along one edge in neat piles and shelved away in mostly-exposed file drawers, a copy machine, metal cabinets full of office supplies, telephones, and, on the walls, health department posters or artistic renderings of mother and child images.

After a patient has signed in, her manila folder is placed on the end of the reception counter on the exam room side of the reception area. Patients are called back one-by-one to do work ups with the nurse. In small offices with an institutional metal desk with a dark wood veneer top patients sit on a chair placed at the end of the desk so that one arm can rest comfortably on the desk to have their blood pressure taken. Patients answer a series of questions about symptoms while the nurse sits at the desk with the patient’s manila folder opened in front of her. After the work up, the patients proceed back to the lobby down the bright hallways with artsy black and white photographs of
naked newborn babies and the gentle adults holding them. As exam rooms become available, the patients’ manila folders are placed in clear plexiglass holders affixed to the wall at eye level outside of each exam room.

The exam rooms have an examining table covered with green leathery plastic that always has the white paper sheets that roll out from the end of the table pulled up over it. The end of the examining table pulls out to extend its length and stirrups can be folded down and stored in the sides of the table. Each exam room has a white counter with white metal cabinets above and below it that hold medical supplies. A metal sink is built into each counter and soap and a paper towel dispensers are nearby. Cylindrical glass jars with chrome lids containing cotton balls, long wooden Q-tips, and tongue depressors line the countertop. A backless round stool with wheels covered with the same leathery green plastic as the examining table is moved back and fourth across the room as the practitioner vacillates between talking to and examining the patients. The stool is set low so that the practitioner sitting on it is eye level with the examining table. The walls of the exam rooms and nurses’ offices all have medical posters adorning them. One typical poster has big teal blue letters that read: “El bebé dentro de Usted” (the baby inside of you). The poster background is light blue and the illustrations of babies in utero at each month are pink. The poster shows the nine months of pregnancy and the development of the baby with drawings and text explaining the anatomical changes as the baby grows.

3.4 Paradigmatic and methodological assumptions

Seidman’s insight that “at the very heart of what it means to be human is the ability of people to symbolize their experience through language” (Seidman, 1998, p. 2)
is central to this study in two ways. First, language itself and how it facilitates or debilitates communication in a health care setting is the topic under investigation. Second, and more to the point Seidman makes, it is the reason this study has been approached from a qualitative perspective. If this study is to lend insight into how programs and institutions might serve professionals who need functional language and cultural knowledge for professional purposes, it must examine those professionals’ perceived needs and wants. Sometimes, curricula implemented by one group to serve another group reflect the same downfall of positivistic research described by Madriz (2000). She claimed that “the knowledge generated by positivistic research tends to reproduce discrimination and prejudice against those groups whose members do not ‘perform’ according to social expectations or do not conform to the stereotypical ideas of researchers” (p. 847). The same is true of curriculum designers who presuppose knowledge of an atypical student population that does not “perform” in the same way as university undergraduates specializing in Spanish and Portuguese, nor do they “conform” to the stereotypical idea of language students. Instead of approaching a potential student population as if it were a subject of natural scientific inquiry, it is important to bear in mind that “the subjects of inquiry in the social sciences can talk and think” (Seidman, 1998, p. 2). Therefore, the present study uses observations to examine the participants’ talk and interviews to elicit the thoughts and ideas of the subjects.

Using a case study of one clinical setting can lend insight into the communicative situation of health care professionals from their perspective, instead of leaving such questions in the hands of outsiders who may lack insider insight into their experiences.
Anyone other than a health care professional working with Spanish-language communication barriers on a daily basis may be less able to pinpoint these professionals’ needs. Case studies yield materials that “parallel actual experience, feeding into the most fundamental process of awareness and understanding” (Stake, 2000, p. 442). At the same time, these professionals operate within the clinic culture work setting.

According to Willis and Trondman (2000), ethnographic research consists of “direct and sustained social contact with agents, and of richly writing up the encounter, respecting, recording, representing at least partly *in its own terms*, the irreducibility of human experience” (p. 5). Through prolonged engagement with this clinic culture, acting as both insider and outsider, the researcher was able to provide a description that is “deeper and fuller than that of the ordinary outsider, and broader and less culture-bound than that of the ordinary insider” (Wilcox, 1982, p. 462).

A case study is ideal for this research project because, as Stake (2000) wrote, “enduring meanings come from encounter, and are modified and reinforced by repeated encounter. In life itself, this occurs seldom to the individual alone but in the presence of others. In a social process, together they bend, spin, consolidate, and enrich their understanding” (p. 442). Beginning with the earliest encounters as a volunteer interpreter, the researcher took an interest in the tremendous richness in the social encounters of those who daily pass through the perinatal clinics. The health care professionals in the perinatal clinics included medical doctors, medical students, nurse midwives, student nurse midwives, social workers, nurses, and nurse’s assistants. The encounters among them were as rich as the discourse across the professional-patient
relationship, where social encounters took on new meaning because linguistic and cultural barriers came into play. The researcher’s mediating presence was another important factor in this case study because she was there not only to examine, describe and later present, explain and analyze the experience of the research participants (Willis and Trondman, 2000, p. 6), but also to facilitate communication by acting as interpreter. This research was designed to lead to a descriptive account of the sociocultural system (Zaharlick, 1992, p. 118) in which communication between native English-speaking health care providers and native Spanish-speaking patients took place.

Having justified using a case study, it is necessary to consider the essential elements of good qualitative studies. Naturalistic study and contextualized observations are mentioned by nearly all who write on the subject (Denzin and Lincoln, 2000; Seidman, 1998; Spindler, 1982; Wilcox, 1982; Zaharlick, 1992). Getting to the heart of professionals’ linguistic and cultural needs and wishes cannot be achieved by sitting in a cubicle reading literature on the topic nor by mailing out a questionnaire designed without consultation with the supposed “target” audience. The researcher must engage in firsthand, prolonged and repetitive observation (Zaharlick, 1992) in order to represent the participants’ views (i.e., the emic perspective) of reality. Another important element, a cross-cultural frame of reference (Zaharlick, 1992), was present in this study on various levels: between the researcher and the participants, among the participants who hold various positions within the clinic hierarchy, and between the health care professionals and their clients. As the participant-researcher, the investigator’s role was to “make explicit what is implicit” (Spindler, 1982, p. 7) to the participants.
In *The art of fieldwork* Wolcott (1995) described important “performance aspects” of fieldwork such as “gaining entrée and maintaining rapport…reciprocity…a tolerance for ambiguity, and personal determination coupled with faith in oneself” (pp. 90-94). The researcher gained entrée by serving as a volunteer interpreter through a transitional period in the summer of 2000 during which there was a shortage of paid interpreters in the clinic setting. Over the three years of the study, the researcher maintained professional rapport and established a reciprocal relationship with the clinic staff by continuing to contribute to the clinic setting by serving as a volunteer interpreter. A personal rapport also developed as the researcher found that one nurse midwife was a neighbor, the spouse of another nurse worked with the researcher’s spouse, and the researcher herself went through a pregnancy and early parenting experiences during those three years. Ultimately, the purpose of this research was to find ways to serve the linguistic and cultural needs of health care professionals such as those in the study. A tolerance for ambiguity and determination was an ongoing struggle in the conduct of this study as the researcher balanced the role of participant with that of observer.

One final element of qualitative inquiry that was significant for this study was the centrality of culture. Willis and Trondman (2000) applied the importance of culture widely to the practice of ethnographic research, insisting on an examination of “the materials-in-use and sensuous practices of ‘meaning-making’ in historical and social context” (p. 9). This issue of “meaning-making” was particularly pivotal in this study because it was quite literally that which was examined—how meaning was made when linguistic and cultural barriers exist. While the researcher examined the culture of the
participants, created by the participants, the more traditional meaning of culture repeatedly came into play as one culture’s view of medical practices repeatedly met with another’s.

3.5 Data gathering

Data for this study was collected through participant observation, conversational interviewing, semi-structured formal interviewing, and documents. For portions of the formal interview that appear in the final report, member checking was employed to get feedback from the informants (Kvale, 1995). The use of multiple methods, or triangulation, for the study represented an attempt “to secure an in-depth understanding of the phenomenon in question” (Denzin and Lincoln, 2000, p. 5).

The time frame for the study was established based on standards of qualitative research as well as the researcher’s experiences during the pilot study. Over a three-year period, the researcher spent time participating in clinic operations as a volunteer interpreter. During this time, the researcher familiarized herself with the people, the routines and the vocabulary of the environment. Likewise, the staff of the clinic had the opportunity to become familiar with the researcher and her roles in the clinic. Early fieldnotes from the pilot study reflected a weakness for vague inferences and abstractions instead of concrete notes that documented that which was observed (Pelto and Pelto, 1996). Later in the pilot period more concrete notes emerged, with short, complete accounts of incidents or conversational exchanges rather than broad impressions (Wolcott, 1995). Participation as an interpreter became so redundant that the researcher had to consciously avoid offering information to Spanish-speaking clients before it had
been offered by English-speaking staff. Indeed, sometimes the staff relied on interpreters to know certain elements of content so instead of saying it in English, they just asked the interpreter to explain that element.

From the pilot study it was clear that rather than more overall time in the field, a greater diversity of hours and clinic environments would be required in order to achieve a depth of experience, become a part of the wider clinic community, and get thick data. This approach required the researcher to travel to the different clinics throughout the workweek like the staff does. The clinic staff was scheduled to interact with patients thirty six hours a week in five four-hour morning sessions and four four-hour afternoon sessions, but often there were periods of transition at the beginning or end of a clinic session when there was little or no patient interaction. Some afternoon sessions that began at 1:00 were finished by 3:00, while most morning sessions did not involve patient interaction in the first thirty minutes.

The three clinics were all staffed by the same people: three charge nurses, two nurses, two nurse midwives, two social workers, three nurse’s aides, one receptionist, one nutritionist, and, on Wednesday, Thursday, and Friday mornings, one medical doctor each. On Thursday mornings, the doctor had medical students shadowing him. In cases where there were activities going on at two clinics at once the researcher went wherever there were more Spanish-speaking clients so that she might both participate as a volunteer interpreter and also observe the staff’s use of Spanish. The division in activities usually meant one clinic was doing intakes, in which new clients had their initial three hour appointment to set up their files, while another clinic was seeing patients for regular
office visits. The only working hours during which observations did not take place were those in which there would have been no possibility of using Spanish. These instances consisted of periodic staff meetings and working hours designated for administrative work instead of seeing patients (Wednesday afternoons).

Formal data collection for the present study in the form of observation fieldnotes, interviews, document collection, and member checks began in late August, 2002. Observation field notes were collected until the point at which fieldnotes started to show a lot of replication and the researcher could anticipate what a participant might say. This point, known as data saturation, occurred in mid-October and coincided with a lull in clinic operations. Fewer patients overall meant fewer Spanish-speaking patients. On one of the last days of observation, the researcher and each of the two staff interpreters interpreted for one conversational exchange each during an entire morning clinic session. The interpreters on the staff were becoming bored by having less and less work to do, eliminating the need for the researcher’s contributions as a participant interpreter. For the remainder of the fall of 2002, the researcher made weekly visits to the clinics to deliver language-learning materials and transcripts of interviews. In January and February of 2003, the researcher concluded member checking with a third interview with informants who had participated in earlier interviews.

The procedure for data collection follows (see Table 3.1). During the first phase the researcher focused on observation, though in order to fulfill the role of participant, the researcher also interpreted in the offices and exam rooms. The first interviews, in which the focus was the participants’ background with regard to communicative needs in
Spanish, were also conducted in the first phase. These interviews took place during the one-hour lunch break. The researcher provided deli lunches and beverages. Each interview was conducted on a different day and all but one were conducted in an empty office or break room in one of the clinics in order to allow for successful audiotaping. The participants were two charge nurses, one nurse, one nurse midwife, and one nutritionist. Throughout the study, the researcher typed up field notes daily using word processing software and weekly imported the field notes into NUD*IST and printed a report on which to manually code the data that was later hierarchically organized in NUD*IST. The researcher transcribed interviews as they were conducted, gave a copy of each interview transcript to the interviewee, and used NUD*IST in the same manner as with field notes, printing reports on which to manually code the data.

The researcher took two one-credit courses on using NUD*IST: Workshop in Qualitative Analysis (introduction to NUD*IST 4.0) and Computer Lab in Qualitative Data Analysis. The first course was an orientation to the software which provided general instruction in how the program is set up to manage qualitative data. The second course allowed students to try NUD*IST on a small scale using their own data. In that course, the researcher used NUD*IST to do some of the analysis for the pilot study of the present project.

In the second phase of data collection observations continued while the researcher tried to help participants meet their expressed communication needs from the first
interview by offering strategies, feedback, and direct instruction where appropriate. Field notes from the observations were transcribed and edited daily. NUD*IST reports were prepared weekly.

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<tr>
<th>Timeframe</th>
<th>Type of data</th>
<th>Format of data</th>
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<tr>
<td>Summer 2000</td>
<td>Volunteer interpreter; observations</td>
<td>Record impressions and intuitions in journal</td>
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<tr>
<td>Fall 2000</td>
<td>Plan pilot study</td>
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<tr>
<td>Winter 2001</td>
<td>Volunteer interpreter; observations</td>
<td>Pilot data in the form of fieldnotes, interview, member check</td>
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<tr>
<td>Spring 2001</td>
<td>Volunteer interpreter; observations</td>
<td>Perceptions, learning routines, focus on participation in setting,</td>
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<td>Summer 2001</td>
<td>Periodic visits to site while designing study</td>
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<tr>
<td>Fall 2001</td>
<td>Periodic visits to site while designing study</td>
<td>Preparation of literature review</td>
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<td>Winter 2002</td>
<td>Prepare dissertation chapters 1-3</td>
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<td>Spring 2002</td>
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<td>Summer 2002</td>
<td>Observations; volunteer interpreter</td>
<td>Hand-written field notes; transcribe and edit field notes; format NUD*IST reports of field notes</td>
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<tr>
<td>Fall 2002, phase 1</td>
<td>Observations; Interview 1, 1 hour each (3 nurses, 1 nurse midwife, 1 nutritionist)</td>
<td>Hand-written field notes; transcribe and edit field notes; format NUD*IST reports of field notes; transcribe interviews</td>
</tr>
</tbody>
</table>

Table 3.1. Timeframe for data collection
<table>
<thead>
<tr>
<th>Table 3.1 continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall 2002, phase 2</td>
</tr>
<tr>
<td>Fall 2002, phase 3</td>
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<tr>
<td>Fall 2002, phase 4</td>
</tr>
<tr>
<td>Following weeks</td>
</tr>
</tbody>
</table>

In the third phase, observations focused on confirming and disconfirming trends that had emerged out of earlier observations. Second interviews were scheduled and carried out with the same group of participants in the same way as the first interviews. The focus of the second interview was the details of the participants’ experiences with communicating with Spanish-speaking clients. This interview yielded rich data because the first interview had started the participants thinking about the topic, as noted in field notes from the second phase. Field notes from the observations were recorded daily using...
NUD*IST and a first draft of interview transcripts was completed to assure successful audiotaping and that all responses were clearly understood by the researcher.

The final phase of observations continued as the researcher found emerging themes in the data from the earlier phases. Field notes from the observations were recorded daily using NUD*IST.

In the weeks that immediately followed phase four, final editing of all interview transcripts was completed. After all the data were coded, analyzed and incorporated into the first draft of the study results, the researcher provided participants with copies of the first draft of chapters four and five of the present study so that they could provide feedback at their third interviews. Third interviews were scheduled and carried out with the same group of participants in the same way as the first two interviews. In addition to serving as a member check of written portions of the study, the third and final interview also focused on reflecting on the earlier interviews as a way of tracking the participants’ own changing perceptions of their communicative abilities and deficiencies.

This study began with participant observation because any form of interviewing in any grounded study, cannot occur until the researcher has spent time in the field observing the behavior of the participants and developing grounded theory. It is from such observations that interview questions emerged. Seidman (1998) described the relationship between observation and interviewing in the following way: “to observe…provides access to their behavior. Interviewing allows us to put behavior in context and provides access to understanding their action” (p. 4).
According to Fontana and Frey (2000), interviewing involves accessing the setting, understanding the language and culture of the respondents, deciding on how to present oneself, locating an informant, gaining trust, establishing rapport, and collecting empirical materials. Conversational interviewing (Wolcott, 1995, p. 106) naturally occurs while in the field. Conversational interviews were represented in the opportunities that arouse during lulls in the clinic action, when staff approached me about an interaction with a Spanish-speaking client that we had seen together. These conversations yielded data about the staff’s experiences and aspirations as language learners.

In transcribing field notes and examining the content of conversational interviews contained there, an interview schedule was devised (Appendix A) that met the goal of having “the participant reconstruct his or her experience within the topic under study” (Seidman, 1998, p. 9). The interview schedule was revised based on pilot interviews and interview data were collected from a wide range of staff members (two charge nurses, one nurse, one nurse midwife, and a nutritionist). Interviewing allowed the researcher to flesh out the trends found in the field notes and gave the participants voice to represent their own experiences and make their own meaning. The researcher used an adapted version of Seidman’s (1998) three interview format in which the first interview covers life history, the second the details of experience, and the third reflection on the meaning revealed in the first two (pp. 11-12).

Data in the form of documents included bilingual health care information published by the health department and promotional materials published by corporations.
Other documents were in the form described by Hodder (2000) as “prepared for personal rather than official reasons” (p. 703). The most interesting documents for this study were the ones produced by the health care professionals, such as the small squares of paper stuck to the walls with Spanish words pertaining to whatever was nearby and word lists constructed by the staff to facilitate their interactions with patients. All of the documents mentioned above serve as “patterned evidence that has to be evaluated in relation to the full range of available information” (Hodder, 2000, p. 710) in the analysis of the data collected for this study.

3.6 Trustworthiness and ethical issues

According to Fine et al. (2000), ethical research points back to some of the basic elements of qualitative research discussed above. Participants must be represented within a richly described context like the above description of the clinic setting for this study. The researcher must be careful to use multiple methods, describe the mundane, use member checks, consider how consumers of the research might use (or misuse) it, and be accountable for one’s work and one’s words (Fine et al., 2000, pp. 126-127). In this study the multiple methods were observation, interviews, document analysis, and member checks. The thick descriptions of the clinic setting and the daily routines at the clinics that developed in the observation field notes provided the description of the mundane. While those thick descriptions were essential to this study of the communicative needs of health care professionals, it was also important to avoid revealing any workplace politics or details of specific medical cases in those descriptions so that the research could not be misused by anyone who might read it. In addition to
serving as one of the research methods, member checks allowed the subjects to participate in the research process by providing feedback to the researcher as the study was written up. Member checks also reinforced confidentiality by allowing participants to contribute their perspectives, interpretations, and even editing powers. Thus, part of an ethical, trustworthy study is built into the design and methods.

Before being able to conclude that this study was trustworthy and ethical, however, some more detailed aspects of the issue must be considered. A qualitative study cannot accomplish its most basic functions if the researcher has not established trust and reciprocity in field (Marshall and Rossman, 1989). For this reason, it was important to always make the role of volunteer interpreter in the clinic primary. Though it may have hurt the data collection on some days, it was essential not to incur a loss of trust because of any perception that the researcher might have been prioritizing her research over helping the staff and patients in the clinic. An intense period of working closely with clinic staff to break down communication barriers often led to a natural debriefing in which a conversation yielded rich conversational interview data. The thick data resulting from these conversations could only evolve after a sense of unity had resulted from working together. Such reciprocity would not have been achieved if the researcher had not been careful to avoid violating the trust of the clinic staff who saw her primarily as a volunteer interpreter, there to help them. Fine et al. (2000) asserted that it is important that the researcher represent his or her own subjective experience and make
that part of what is problematized (p. 109). To leave out discussions of the conflict that may have resulted from my dual role as participant and observer would have damaged the trustworthiness of the study.

From a more practical perspective, the researcher sought to fulfill some basic criteria of ethical, trustworthy research as described by Christians (2000). These criteria include informed consent, avoidance of deliberate misrepresentation of participants, and respect for privacy and confidentiality. To comply with the issue of informed consent, it was made clear to the clinic supervisor, with whom the interpreting was arranged, and all conversational interviewees that the researcher was also conducting this study. When asking for a document it was made it clear that it would be used for a document analysis. Before recording any formal interviews with the clinic staff, an information sheet explaining the study (Appendix B) as well as a consent form to sign (Appendix C) were provided. A copy of both was provided to the interviewees for their records. None of the participants were deliberately misrepresented in this study. Privacy and confidentiality were honored, even at the expense of recording data or specific details of conversation in the fieldnotes. The need to “protect people’s identities and those of the research locations” (Christians, 2000, p. 139) is important in medical settings.

3.7 Description of data analysis procedures

The data collected in this case study were analyzed following the premises of grounded theory. Ryan and Bernard (2000) characterized grounded theory as “an iterative process by which the analyst becomes more and more ‘grounded’ in the data and develops increasingly richer concepts and models of how the phenomenon being studied
really works” (p. 783). Essentially theory emerges as one collects and analyzes data in
the field. Analyses conducted while in the field directly impact further data collection.
Charmaz (2000) described the data analysis that occurs while conducting a grounded
study in the following way:

grounded theory methods consist of systematic inductive guidelines for collecting
and analyzing data to build middle-range theoretical frameworks that explain the
collected data. Throughout the research process, grounded theorists develop
analytic interpretations of their data to focus further data collection, which they
use in turn to inform and refine their developing theoretical analyses (p. 509).

Though it may sound unsystematic to those accustomed to more traditional data
analysis techniques, grounded theory is not without structure. In fact, in order to keep up
with a grounded study, the researcher must code data as it is collected, making
comparisons, categorizing, and defining data as he or she goes (Charmaz, 2000, p. 515).
This ongoing analysis of what has been previously collected must occur in order to be
able to refine present and future data collection in the field. According to Ryan and
Bernard (2000) grounded theorists are engaged in finding themes induced from text (p.
780), building codebooks as data is reduced (p. 781), and using grounded theory “to
understand people’s experiences in as rigorous and detailed a manner as possible” (p.
782). Thus, a systematic process of data collection like the one described above for this
study is required to sort out the details significant to the study as well to reduce the
massive quantities of data that one collects in such a “rigorous and detailed” examination
of a sociocultural environment.

Because of the nature of this study, much of the data analyzed was in the form of
“talk.” In “Analyzing talk and text,” Silverman (2000) regarded talk as important data
and examined three forms of talk: interviews, texts, and transcripts. Confidentiality issues in the present study eliminate the possibility of analyzing transcripts of natural talk; instead, this study relied on analyses of field notes. However, interviews and texts did form a significant part of the data for this study.

Silverman (2000) recommended using interviews to access “stories or narratives through which people describe their worlds” (p. 823), an approach that brings out challenges to the view that interview responses reflect some external reality. According to Silverman, a researcher must ask himself or herself five essential questions in analyzing interview data. In analyzing interview data for this study, those questions were addressed. Following is a list of the questions and an explanation of how each one impacted data analysis:

• *What status do you attach to your data?* (p. 824) Do people attach a single meaning to their experiences or are there multiple meanings to a situation revealed through constructed narratives? The researcher has to choose and defend his or her view. This study employed five participants and a series of three interviews in order to explore the multiple meanings related to health care professionals’ communicative needs in Spanish. Each participant constructed her own narrative as meanings changed and evolved across the three interviews. Not only were there multiple meanings represented by the four participants’ perspectives, there were also multiple meanings for each participant over time.

• *Is your analytic position appropriate to your practical concerns?* (p. 825) This is a reminder not to make analysis more complicated than it is; it is okay to have a
descriptive study. For this research, the culture under study was a workplace and the
cultural phenomenon examined was linguistic and cultural communication. In
analyzing data, the researcher sought to describe the communicative needs of the
health care professionals participating in this study.

- *Do interview data really help in addressing your research topic?* (p. 825) Again, this
  is an admonition not to unnecessarily complicate matters—document analysis or
  observation may be better than interviews for a given study. One must constantly
  evaluate the relevance to his or her study of the data collected. In this study,
  interviews were the only way to gain direct access to the participants and their
  perceived communicative needs as those perceived needs evolved. While observation
  and document analysis were essential to provide thick description, frame the
  interviews and develop most of the ideas discussed in the interviews, the interviews
  themselves provided the central data regarding both participants’ communicative
  needs and how best to address those needs.

- *Are you making too-large claims about your research?* (p. 825) One must be careful
  to make limited claims. While examining the communicative needs of the study
  participants with the immediate goal of improving communication for those
  participants, it was left for future research to confirm that a wider population
  experiences the same needs and to develop curricula that might serve those needs.
  Neither issue fell within the scope of this qualitative study.

- *Does your analysis go beyond a mere list?* (p. 825) Beyond identifying the main
  elements in data, the researcher must link those elements in such a way that
something original is revealed. The list of communicative needs for health care professionals emerged early in the study. It required analysis of the data collected to reconcile issues such as the differences between the researcher’s list and the participants’ list. Data analysis also lent insight into how the various communicative needs might best be met.

With regard to textual analysis Silverman (2000) warned that texts are still constructions so a researcher must not fall into the trap of regarding texts as inherently true. Again, successful analysis goes beyond a mere list to include deep analysis beyond the more superficial coding. In analyzing text, one must also be careful to limit the amount of data to be analyzed so that a detailed analysis may be conducted on the data that is chosen. For this study, membership categorization analysis (Silverman, 2000, pp. 826-827) was used as a way of examining how research participants categorized experience instead of relying on the researcher’s imposed categorizations. This pertains to the aforementioned discrepancies in the researcher’s and participants’ lists of communicative needs.

The triangulated data collected in this study were managed using NUD*IST software. Being careful not to mistake data management for data analysis (Charmaz, 2000), NUD*IST allowed for coding, observational notes, theory notes, and operational notes. It is from observational notes written by the researcher that grounded theory emerges. Theory notes involve interpreting the data that is coded while operational notes concern practical matters involved in data management (Ryan and Bernard, 2000, p. 783). NUD*IST acts as a data base program while it allows for the building of concepts.
and models that can easily convey that which can be complicated during data collection procedures. Once the data are coded, triangulated, and analyzed, patterns in the responses can be established.

3.8 Pilot study

During the eight weeks of this study, the researcher spent every Tuesday afternoon from approximately 1:00 to 4:00 in the clinic on the east side of the city. One staff serves all three clinics, with varying overlap depending on the day and the schedules at each of the clinics. By being at the same site on the same day of the week, the same core group was always observed at work: three nurse midwives, one student nurse midwife, a charge nurse, three registered nurses, two nurse’s assistants, one social worker, and the Women, Infant and Children nutritionist (Appendix D). On Friday of the fourth week a formal interview with the nutritionist was conducted in her office at the clinic on the west side of the city.

Data for this pilot study were collected through participant observation, conversational interviewing, semi-structured formal interviewing, and documents. For portions of the formal interview that appear in this report, member checking was employed. The use of multiple methods for the small-scale study represents an attempt “to clarify meaning, verifying the repeatability of an observation or interpretation” (Stake, 2000, p. 443).

In following Stake’s (2000) characterization of qualitative case study as primarily involving “researchers spending extended time, on site, personally in contact with activities and operations of the case, reflecting, revising meanings of what is going on,”
(p. 445) the researcher volunteered as an interpreter in the clinic one afternoon a week for three hours during a period of eight weeks. Experiences in the clinic fit the pattern described by Patton (1990) in which a few key informant names emerge over time (p. 176). Two charge nurses are regularly admired for the Spanish they have acquired. A few staff members appear to have made little effort beyond using their high school Spanish. Most fall between the two extremes. Because only one interview was conducted for this study, one of those “middle” users of Spanish from whom a lot could be learned was chosen.

While in the field, a variety of data in the form of documents were available. Some were in the form of publications produced by the health department or even for-profit companies, others in the form described by Hodder (2000) as “prepared for personal rather than official reasons” (p. 703). One nurse and the social worker were particularly prolific sources of published documents. The nurse always gave me a copy of any Spanish-language materials she handed out to Spanish-speaking clients. The social worker gave me any and all promotional materials. She gave me those things because of my own pregnancy and I instinctively fished out the free pacifiers and baby body wash and threw away most of the advertisements and informational literature, whether it was in English or Spanish, before realizing what rich data they could be.

Interesting documents for this study were produced for personal reasons (Appendix E). Throughout the clinic little pieces of paper were stuck to the walls with Spanish words pertaining to whatever was nearby. There was one next to the scale, one next to the exam table in the charge nurse’s office, and one on the wall next to the social
worker’s desk. In one case, the researcher was asked to help construct a document for the student midwife. She asked me how to say a series of words that would have served her if she had known them in an uncomfortable exam situation. The following week, when asked for a copy of the document, the student midwife provided a twenty-page “official” document that had a wide range of obstetric terminology translated into Spanish. All of the documents mentioned above would serve as “patterned evidence that has to be evaluated in relation to the full range of available information” (Hodder, 2000, p. 710) in an extensive analysis of the data collected for this study.

3.8.1 Preliminary findings

It was found that when a language barrier between health care professionals and patients was present, a desire to successfully communicate existed. No antagonistic frustration at patients’ inability to use English was observed. Only occasionally, and usually with amusement, did clinic staff appear frustrated at their own inability to communicate information in Spanish to a patient (see Appendix F for a preliminary analysis of the kinds of communication that typically took place in the clinic).

Most of the professionals observed either had a “script”--the word one of the nurses used for the fixed expressions she was able to use to communicate with Spanish-speaking clients--or relied entirely on interpreters, at least when the researcher was present to interpret; no data were gathered on what happened when an interpreter was not present. “Script” was an appropriate term for the nurses because they repeated the same things with virtually every patient before and after the exam. The clinicians appeared to not have attempted to advance beyond their high school Spanish, but a lack of interest in
learning Spanish cannot be assumed because their interactions in exams varied from patient to patient so development of a “script” was more challenging for them.

The “scripts” that many of the nurses had developed reflected significant language learning, at least in the area of language production. Many of them could say almost everything they needed to say to a patient and communication broke down only when the patient response was something other than “sí” or “no.” The same staff members who could say a lot of what they needed to in Spanish, had a severely limited understanding of non-scripted spoken Spanish.

The details of a serious lack of listening comprehension skills came out in the formal interview with the clinic nutritionist. When asked to explain how what happens in her office differs with Spanish-speaking clients and English-speaking clients, the nutritionist stated that “on a one-to-one basis that they would lack….with questions that they have, problems that they have….that I don’t know if I’m able to answer. There’s a lot of confusion.” She tried to explain in general terms what was lacking for her Spanish-speaking clients as compared with English-speaking clients, but other than the word “lack” she struggled to come up with a generalization. She then proceeded to list examples of what was lacking—answers to questions, solutions to problems. Finally, she did conclude the turn with a generalization—that her interactions with Spanish-speaking clients were characterized by confusion.

Repeatedly throughout the interview it was her own inability to understand and respond to the Spanish-speaking clients’ questions and concerns that she cited as the biggest impediment to communication. At one point she suggested that having a Spanish
version of the video that introduces new clients to the Women, Infants and Children program would be more effective than her best attempts to communicate the message to Spanish-speaking clients. However, she was quick to point out that even if her message were effectively conveyed to Spanish-speaking clients via video, she would not be able to address the questions and concerns resulting from the video: “the only thing is there’d be no…then you wouldn’t have any questions….if there was any questions about the video (accenting the ‘o’) then there’s nothing I could do about that.” She seemed most concerned about the issue of being able to address her clients’ needs as expressed in their first language.

Eventually the nutritionist likened her inability to answer Spanish-speaking clients’ questions, solve their problems, and provide them with feedback with an inability to get her job done. Ultimately, she felt that material things (videos or pamphlets in Spanish), “if you can’t communicate with them,…[are] pretty worthless. You know, because if they can’t ask questions, if they can’t….do something, some kind of feedback, then my job isn’t done. So that to me would be the biggest thing, being able to answer the questions or being able to solve the problems.” The feeling that her job was not done if she could not communicate with her clients showed both her concern for doing her work completely and thoroughly and her concern for being able to communicate with all clients on a basic linguistic level. Her own inability to understand spoken Spanish was something she viewed as an inadequacy on her part.

As the interview proceeded, she became more explicit about identifying listening comprehension skills as her primary need. At one point she said “learning how to hear
it…because I can speak it, but as soon as (*voice cracking with amusement*) somebody talks to me in Spanish it is like (*eyes widen and she shakes her head*)…so communications I think would help just the hearing it.” It is worth noting that in the preceding example she resorted to non-linguistic communication in her explanation of an inability to communicate using language. In her description of what it was like when someone spoke to her in Spanish she did not use words but just showed how she registered incomprehension with wide eyes and a shake of her head that said “no” as in “I don’t understand a word of it.”

Later she explicitly acknowledged that her production skills were almost as good as they needed to be by saying that she could read out loud anything that was written, but if someone were to read those same words to her, she would not understand any of it. She said, “they could write it down and I could say it, but if you would, you know, read like something to me in Spanish…I wouldn’t understand it. Not a word.” This was a significant contrast that pointed to listening comprehension as the primary gap in communication. She was claiming that she was quite comfortable producing the language orally, but that the same things she could produce would be entirely incomprehensible if spoken to her.

The nutritionist was able to articulate where her listening strategies broke down as she attempted to communicate either with an interpreter or one-on-one with a Spanish-speaking patient. In the following interview excerpt she talked about her inability to understand in terms of keeping up with rapid spoken language, the inability to put recognizable words into context, and the need to actively practice listening: “like you’d
be talking like ten words I didn’t understand and all the sudden there’d be three words I understood, but I can’t put it in the context of what you’re trying to say….It doesn’t matter what you’ve said, once I’m not into tune with what you’re saying, then I can’t…So I think, practice.” She was aware enough of her language skills and lack thereof to identify the breakdown in listening strategies she experienced. She also recognized that some kind of practice would help her “tune in” to more of the words. This quote was important because she articulated her metacognitive awareness. She was able to identify that which she did not understand, reasons for her inability to understand that which she did know, and ways to improve upon the situation.

Near the end of the interview, she again reiterated her need to improve listening comprehension skills since her clients will always communicate with her orally, but she was pessimistic about the possibilities. In trying to describe what kind of practice she needed, she said “I personally think, but it would almost be impossible, the feedback in hearing it because I need to learn how to hear it.” Because she viewed learning how to hear as “almost impossible,” she did not conceive of resources that would help her to be a better listener, thus many of her responses to what she thought would be useful contradicted her previously stated needs. It was as if she had a list of realistic resources that she felt she could pursue and listening comprehension could not be achieved through any of those available or potentially available resources.

Despite the clear indication throughout the interview that listening comprehension skills were the most salient gap in her Spanish language skills, each time she was asked about resources to help her communicate with Spanish-speaking clients she fell back on
“traditional” resources. After having expressed frustration with the overly simple language and culture (see Appendix G for an assessment of cultural sensitivity in the clinic) classes offered by the health department that spent two classes going over greetings and the alphabet, she suggested that “one thing that would help is just a general class like a refresher class ‘cause I think I remember quite a bit of having it in high school….also look into computer related software. I have a little CD that helps a little bit, too… (voice softening) with some things.” The mention of a compact disc indicated that she had a sense of technological advances in language learning materials, but she failed to see any possibilities for language learning beyond the traditional “refresher course” or refresher course materials on a compact disc.

When trying to conceive of an alternative to the less-than-useful Spanish class that was offered by the health department, she came up with a surprising suggestion for one who had acknowledged a need for listening skills as paramount. She concluded her comments against the boring class that went over greetings and the alphabet with, “so I think what would help is like a workbook-type thing.” Earlier in the interview she had indicated the importance of listening skills and now she suggested a resource that involved nothing but reading and writing. She appeared to be locked into the view of resources as material. When pushed on the usefulness of writing practice and using a workbook, she again said that practice hearing it was what she needed most.

The clinic nutritionist was not alone in her mentality that appropriate language resources were material and that the central place for learning a language was the classroom. As a classroom instructor of Spanish, the researcher was accustomed to the
typical pattern of language acquisition in which students first master reading and writing, then listening skills, and finally speaking skills. In fact, much of the data gathered was not consistent with Krashen’s Monitor Model, the most dominant, though admittedly controversial, theoretical model of language acquisition. Of interest here were two of Krashen’s hypotheses: the monitor hypothesis and the input hypothesis. The monitor hypothesis asserted that subconscious acquisition accounts for all fluency in output of the language and that formal, conscious learning can only serve as an editor, or monitor, for output. The data collected in the clinic setting, however, seemed to show a surprising lack of acquisition despite a relatively high level of fluency in spoken Spanish. Those health care professionals who appeared most fluent had learned Spanish in a rather formulaic fashion, memorizing fixed expressions provided by written sources or bilingual acquaintances. The repetitive and formulaic nature of the language they needed to use gave a strong impression of fluency in output, but it could not be accounted for by subconscious acquisition.

At the same time, and more in line with Krashen’s monitor hypothesis, it remained clear that traditional, conscious learning was not the answer to the health care professionals’ imbalance between production and reception. Eventually in the formal interview with the clinic nutritionist, she got to the heart of what had been overlooked in the Spanish classes offered through the health department when she said, “I think most people here have tried so hard to learn Spanish that if we go to an introduction thing somewhere, we already know that. I don’t need to learn the alphabet…I’m above that.” This is consistent with Krashen’s assertion that classroom instruction is most useful to
beginners. However, his model fails precisely at the point where one might ask how to best to proceed with language learners in the situation described here.

Krashen’s input hypothesis contends that language learners acquire language only through exposure to “comprehensible input.” Included in comprehensible input is language that is slightly beyond the learners’ current language level. The supposition is that learners will use context, world knowledge, and extra-linguistic cues to understand the content that is beyond their current level. In the clinic setting, however, not only could learners not understand beyond their language level (if we use speaking ability to gauge level), they could not even understand spoken language at or below their own production level. Their production seemed to conform with the audiolingual approach because they learned to listen and repeat pertinent words outside of any real linguistic context.

The clinic proved to be an environment in which potential language students’ spoken production skills were as strong as they needed to be while their receptive skills were almost completely lacking. This seemed to contradict Krashen’s caution that “students should never be required to produce speech in the second language unless they are ready to do so. Speaking fluency cannot be taught, but ‘emerges’ naturally in time with enough comprehensible input” (Omaggio, 1986, pp. 30-31). While the clinic staff’s spoken skills have “emerged” over time (though probably not naturally), they appear to be unrelated to comprehensible input from any kind of natural source.
3.9 Conclusion

Now having presented the details of the methodological procedures, including a
description of sampling and sampling procedures, paradigmatic and methodological
assumptions, data gathering techniques, trustworthiness and ethical issues, and a
description of data analysis procedures, the focus of the study now turns to a discussion
of the results of the research. The pilot study discussed above was used to refine the
methodological procedures so that the results might be presented with clarity. Chapter
four examines the language acquisition of health care professionals in an attempt to
determine what elements would be useful in Spanish language and culture curricula for
health care professionals. The following chapter is organized around the research
questions presented in chapter one, which deal with the communicative needs of health
care professionals working with Spanish-speaking clients in perinatal clinics.
CHAPTER 4
RESULTS AND DISCUSSION

4.1 Introduction

This chapter revisits the research questions presented in chapter one, beginning with an examination of the nature of communication in the clinic setting. This will provide a context from which to discuss the language acquired by professionals on the job, how such language is acquired, and what linguistic and cultural needs the professionals still have. Finally, issues of reciprocity and power dynamics will be discussed in terms of their relevance to language of communication in the perinatal clinics in which this study was conducted.

The chapter begins with participant portraits that will serve as an introduction to the participants who will appear throughout the chapter. The learner portraits have also been designed to frame the rest of the chapter by showing the range of learners with their various backgrounds, needs, and goals in a case study with only five participants. The range of learners in a traditional classroom might be even greater.

4.2 Participant portraits

Some of the clinic staff felt they were already too busy professionally and would prefer to rely on interpreters to communicate with Spanish-speaking patients (week 4, fieldnotes, 568-570); therefore, it is noteworthy that all five participants in this study had a high level of comfort with their own professional skills that allowed them to focus time
and energy on their use of Spanish in the workplace. Those who participated in this study all expressed an interest in learning enough Spanish to not always depend on interpreters. Table 4.1 summarizes the participant portraits.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Prior Spanish-language experience</th>
<th>Uses of Spanish in workplace</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth</td>
<td>Nurse</td>
<td>4 years high school Spanish</td>
<td>patient interviews</td>
</tr>
<tr>
<td>Bernice</td>
<td>Charge nurse</td>
<td>4 years high school Spanish, 3 years high school Latin 2 classes offered by a local department of parks and recreation</td>
<td>patient interviews, exiting, coordinating, appointment-making, initial visits (intakes), telephone calls</td>
</tr>
<tr>
<td>Gretchen</td>
<td>Charge nurse</td>
<td>high school, travel to Mexico as a child</td>
<td>patient interviews, exiting, coordinating, appointment-making, initial visits (intakes), telephone calls</td>
</tr>
<tr>
<td>Kim</td>
<td>Nutritionist</td>
<td>high school, part of a Health Department Spanish class</td>
<td>nutrition counseling, distribution of food coupons</td>
</tr>
<tr>
<td>Nancy</td>
<td>Nurse midwife</td>
<td>high school 1 class offered by a local department of parks and recreation</td>
<td>patient exams</td>
</tr>
</tbody>
</table>

Table 4.1 Summary of participant portraits
Beth

Beth has been an obstetrics nurse since 1989. She worked on a hospital labor and delivery floor until two years ago when she began work at the perinatal clinics. She came to the job thoroughly prepared to fulfill the nursing work required, but she was concerned about her ability to communicate with clients who did not speak English. According to a colleague, “her biggest stress of the job…wasn’t anything medical, it was the language” (Bernice, interview 2, 794-796). For Beth, one of the greatest challenges of her current position has been building upon her four years of high-school Spanish in order to communicate with Spanish-speaking clients.

Beth cited interpreters as her main resource for communicating with clients (interview 1, 209-210) and on a scale of one to five rated her Spanish-language proficiency as “maybe a one and a half” (interview 1, 182), adding, “I don’t think it’s very good” (184). On a cognitive-informational level, she has mastered the production of the basic interview questions that begin each patient’s visit. She routinely combined her own production skills with interpreter support to communicate with patients. In her first interview, she acknowledged her skills and her limitations, saying, “I try to get through an interview with the patient as much as I can--am comfortable with--by myself and then if I have anything more than just the basic questions that I know I can handle, then I kind of save all that for last, then call the interpreter…and then do all the stuff I know I need the interpreter for later” (interview 1, 212-217). The researcher observed this pattern in
the following exchange with a patient that included the use of an interpreter (the researcher) to explain a procedure that strayed from the normal interview schedule:

Beth (standing next to scale): Su peso.
Patient takes off shoes. Her little boy sits on a chair. Patient gets on the scale.
Beth: (Writing at the counter) OK.
She moved to the desk with the chart, put the cuff on the patient’s arm and as she put on the stethoscope, said
Beth: Tres libras más (widening eyes informatively)
Beth took blood pressure, wrote, used wheel--silence for more than a minute.
Beth: ¿Tiene hinchazón en las manos…?
Patient: En las manos, sí.
Beth: ¿y en los pies?
Patient: Cuando trabajo.
Beth: ¿Tiene dolor de cabeza? (No)
Beth: ¿Problemas con la visión?
.
.
.
Beth: ¿Flujo vaginal?
Patient: Sí. Normal. [anticipating next question]
Beth: ¿Dolor o problemas?
Patient: No.
Beth: ¿No? ¿Todo bien?
Patient: Sí.
Beth (getting out a paper): That’s in English (mumbling to herself). Put paper on the edge of desk. Looked at researcher.
Beth: Now this is when I’d go get an interpreter.
Researcher (looking at document): Oh, fetal movement. (Researcher explained the paper and counting fetal movements twice a day).
.
.
.
Beth: ¿Está tomando las vitaminas?
Patient: Sí.
Beth: ¿Se mueve el bebé?
Patient: Sí.
Beth: ¿Necesita más vitaminas?
Patient: No. Por eso subí 3 libras. Más vitaminas que tomo, más subo.
Researcher (to Beth): She thinks the weight gain is related to vitamin-taking.
Beth (smiling): ¿Muestra de orina hoy?
Patient: No.
Beth: ¿Necesa cupones de WIC?
Patient: Sí.
Beth (writing, then): In your next visit. La próxima cita, en 2 semanas…examen pélvico.
Patient: ¿No hoy?
Beth: No.
I look up and we all smile.

Beth did not use Spanish for social-psychological communication, but she did say that her long-term goals included being able to do more social-psychological communication so that she could get to know Spanish-speaking patients and learn about “different social factors affecting their pregnancy” (interview 2, 234-235) like she did with English-speaking patients. When asked in her second interview what her needs were with respect to communication in Spanish, she said “more of being able to talk to somebody, more conversational kinds of things” (interview 2, 400-401). Beth needed Spanish only for work, but would like to add to her base of productive abilities, and be able to understand more spoken Spanish. She was not optimistic about improving upon her current level of Spanish “without some kind of…structured education” (interview 2, 364-365) and she felt that her resources did not allow her to pursue Spanish on her own time or at her own expense.

**Gretchen**

Though she was the oldest participant in the study, Gretchen was the newest to the field, having chosen nursing as a second career. She graduated from nursing school in 1993 and was a medical-surgical hospital nurse for eighteen months before moving to obstetric and gynecologic nursing. She had been in her job as a charge nurse at the clinics
for three years. By the time of the third, member-check interview for this study, Gretchen had left the job in obstetric and gynecologic nursing for a position in an immunization clinic.

In addition to having studied Spanish in high school, Gretchen had traveled to Mexico with her family as a young child. It was noteworthy that she remembered the words her father had taught her then, such as “leche,” “pan,” and “cuidado.” She added, “I suppose as a child being told to be careful is something that sticks with you” (interview 1, 800-801).

Gretchen characterized her Spanish proficiency as a “minimal. Muy, muy poquito” (interview 1, 242). On a proficiency scale of one to five, she said she would be a one. Gretchen had a strong sense of her Spanish-language skills and limitations and was able to articulate that immediately. She talked about having a memorized script: “I developed [it] when I first came because there’s certain things that you do need to find out from a patient…every time you see them. One is a list of symptoms. And another is ‘have you given a urine specimen?’… ‘today?’” (interview 1, 210). The script of symptoms that Gretchen mentioned are the same ones that Beth used in the excerpt cited above and, as Gretchen stated, those questions are the same for every patient at every visit (see Appendix H). These are quintessential cognitive-informational interviews.

As a charge nurse, Gretchen frequently had to communicate with patients about things outside the realm of her “script,” both in person and by telephone. The charge nurse had to coordinate each patient’s visit as she moved through the clinic’s lab, work-up rooms, exam rooms, nutrition office, and social worker’s office. At the end of each
visit the patient was “exited” by the charge nurse who went over any orders given by the practitioner, made appointments ordered by the practitioner, and ensured that the patient had made all the necessary stops in the clinic that day. The charge nurse also created the patient file at an initial visit called the “intake” appointment. During the “intake” the patient’s medical history was reviewed and a mountain of paperwork was produced. Though routine, these other responsibilities of a charge nurse did not allow for communication with a fixed “script” like the regular patient interviews did.

Gretchen would like to learn more Spanish, both for work and for social purposes, such as travel, and repeatedly said that she just needed to “do it,” but cited lack of time as the primary hindrance to improving her Spanish. In her first interview she said, “I keep buying books and…they sit there and occasionally I open one up like I did this morning to look up a verb” (218-219).

Bernice

Bernice was a charge nurse at the clinics who had been in nursing for almost thirty years. She had worked in the perinatal clinics for a total of ten years. In addition to her work in the perinatal clinics, she had also worked in home health care, well-child clinics and immunizations, neighborhood health centers, and in the mother/infant unit of a hospital. Bernice cited the opportunity to learn and use Spanish as a reason for wanting to work at the perinatal clinics: “when I first came back to work here, I told people that my favorite thing about the whole job was trying to speak Spanish” (interview 2, 787-788). In addition to four years of high school Spanish and three years of high school Latin, Bernice took two classes at a local Department of Parks and Recreation and bought
some books (interview 2, 790-791). She said the classes were “for people going on
turcation mostly...[it] didn’t really focus on the medical, but still it was good to learn
some words, because we do talk about nutrition” (interview 2, 669-675). Last year she
went to Mexico as a tourist.

Bernice characterized her own Spanish as “survivable” (interview 1, 162). When
asked to rate her Spanish language proficiency on a scale of one to five, she said, “maybe
I’m a three or maybe three and half or...with some people, a four” (interview 167-168).
She concluded that she would have to rate the relative success of each conversation with
each patient rather than rating her overall proficiency.

Like Gretchen, Bernice’s role as a charge nurse required that she frequently
communicate by telephone, coordinate patient visits, make appointments, conduct exit
interviews, and conduct initial “intake” interviews with new patients in addition to
performing the work-up interviews that began each visit for every patient. Reflecting her
desire to communicate with Spanish-speaking patients, Bernice often conducted social-
psychological conversations in addition to cognitive-informational interviews. Early in
her first interview with the researcher she said, “I love to make conversation. So I like
to...you know, just ask the general how are you? I like your clothes. I like your dress.
Your hair’s pretty...you know, something. If they have a baby I like to say
something...nice” (77-80) before beginning to interview the patient.

Her interest in communicating on a personal level with every patient was not
limited to Spanish. She said she tried to include “pleasantries” in every interaction and
mentioned that some people from Ghana speak “Twi” and she “wrote a few things down
just cause it’s fun. It’s an icebreaker” (interview 1, 702-709). Twice in her second interview, she said she liked to “chit chat” with people (594; 1099) specifically so that she could learn Spanish, adding, “because you have to know more than just the medical words, you have to put sentences together” (interview 2, 594-598). An example of her creating social-psychological communication was her greeting to the interpreters one morning: “buenas* días a todas las señoras que hablan español” [good morning to all the Spanish-speaking women]. When one of the interpreters answered, “y Usted también” [and you, too], Bernice smiled and said “thank you!” She was more appreciative of being included in the group of “señoras” who speak Spanish than being wished a good morning (week 6, 175-178).

Her success with learning Spanish seemed to be tied to a sense of how to learn the language. In her first interview she said that it was best to “learn by doing,” adding that she enjoyed having an interpreter with her when she used Spanish so the interpreter could act as “the security blanket or the…teacher, really” (interview 1, 626). She used the interpreters to both test her hypotheses--guessing what was said by the interpreter and patient--and to learn from her mistakes, which she liked having pointed out to her.

Her goals for learning more included a stay in Mexico and her desire to learn by doing persisted: “I wish I could go and stay somewhere for a couple months and just really do it. That’s the best way” (interview 2, 590-591). She did not want to return to Mexico as a tourist, nor merely as a language student. Bernice’s goals for a study abroad experience included “placement in the clinics down there. You know, so I could see where the patients are coming from” (week 2, 16-17). Her primary goal of working in a
medical setting in Mexico was followed by the realization that “you [have to] do more than that. You have to be living in…you know? Because things come up about other things” (interview 1, 671-678). This need to communicate about non-medical topics became a recurring theme throughout this study.

**Nancy**

Nancy, a nurse midwife, was the only practitioner (also called provider or clinician) who participated in the study. Nancy described the work of a practitioner in her first interview: “I see the pregnant women after they’ve…been initially seen by somebody else and weighed and their blood pressure taken and they’ve had an initial interview and then I see them and do an exam and kind of make further assessments of any problems they might have or questions….and then make a plan of care” (44-49).

Nancy had been a nurse midwife for eighteen years and had held her current job for nine years. She had also worked in the private sector and for a nursing service in a rural area.

Nancy had taken Spanish classes in high school as well as one class at a local Department of Parks and Recreation. During the course of this study, Nancy used many of the same learning techniques she had used in high school (interview 2, 277-280). In her first interview she said the recent influx of Spanish-speaking patients was “a great opportunity for language learning, but…you have to make that conscious effort to really work on it and have a resource” (interview 1, 780-782). Throughout the study, Nancy took advantage of the researcher’s presence as a resource, writing down words and phrases she needed to be able to say in Spanish in order to fill out her ability to
communicate with Spanish-speaking patients. After writing out the Spanish equivalents, she practiced out loud before trying her newly-learned Spanish with patients.

In her first interview Nancy said her Spanish was “at a very basic level” (103) with which she could “get through a routine exam with somebody—if there aren’t a lot of problems” (interview 1, 106-108). Nancy expressed an interest in “bump[ing] up to a new level” (interview 1, 105) from what she considered her “incredibly, ridiculously basic” (interview 1, 384-385) use of Spanish. In her second interview, Nancy said she felt that she had improved and that her improvements “helped me to see what I can…continue to do as well. So I’m kind of at a new level and…my motivation…[is] my understanding of what’s helpful and what I need to do to continue” (interview 2, 20-22).

Like Beth, Nancy combined her Spanish-language skills with the help of an interpreter. She often began the exam with a patient and then got an interpreter to follow-up, confirm, and communicate on subjects that she and the patient could not manage on their own (interview 1, 138-151). Nancy pursued mostly cognitive-informational Spanish, but with the direct instruction started adding social-psychological elements such as, “hopefully you’ll have the baby soon” [ojalá que tenga el bebé pronto] (week 5, 577-587).

The linguistic needs of a practitioner like Nancy were unique in that there was no basic script that she could rely on because the initial interview with each patient was always conducted before the exam. While there were routine aspects to the practitioner’s work, the exam room was where each patient’s unique issues were discussed. The fact that the practitioner had to conduct an exam also eliminated any reliance on written
materials to aid communication with Spanish-speaking clients. Nancy pointed at that for others in the clinic it might be appropriate to read questions while proceeding to fill out a form, but that such an approach to learning language would not work in the context of an exam (interview 1, 617-621).

In her first interview, Nancy said that she would like to improve her basic Spanish in order to “get through…more visits and ask more questions and hear more from people, have more dialogue even if I still wanted to have [an interpreter]…help me with people who I was especially concerned about” (interview 1, 283-298). She acknowledged that as the practitioner, she would probably never “feel secure giving somebody some information…about warnings and symptoms” or dealing with “somebody that I was really concerned about or really worried about” without an interpreter (interview 1, 284-287). Just as Bernice expressed a desire to communicate about non-medical topics, a few weeks after her first interview, when she had improved her basic level of Spanish, Nancy expressed a desire to “branch out…to be able to say more than just medical stuff and be able to use it outside of work” (week 5, 525-530).

**Kim**

Kim was the Women, Infant, and Children nutritionist who worked at the clinic. Her role was to offer nutrition counseling to the pregnant patients as well as coordinate the distribution of food coupons. She took Spanish in high school and attended a few classes offered by the health department. She considered herself a beginner because of her limited productive vocabulary and difficulty in understanding spoken Spanish. When asked to rate herself on a scale of one to five, she said, “probably two” (interview 2, 59).
Kim relied on interpreters to communicate with patients, but also invited the researcher to sit with her and help her use Spanish with the patients. It was through such encounters that the researcher was able to develop a script to help Kim fill out her rudimentary explanation of the food coupons to a new patient. Nutrition counseling, however, varied with each patient beyond the basic advice for coping with morning sickness, appropriate pregnancy nutrition and weight gain, and breastfeeding. In the second interview, Kim suggested that the greatest excitement in her work was not her job as a nutritionist, but the challenge of trying to use Spanish to communicate with Spanish-speaking clients. She characterized it as “a new learning experience” and “another challenge for me” (interview 2, 921-927; also interview 3, 393-396). Kim would like to become fluent. She said, “I would love to continue taking something…to where I’m able to be…fluent” (interview 2, 713-714). Even with such motivation, finding a way to continue her Spanish-language education had eluded her. Her full-time job did not allow her much free time. Like the CD-ROM she used at home, the course offered through the health department that did fit her schedule covered basic things she remembered from high school so she stopped attending.

4.3 Research question 1: What is the nature of communication between health care professionals and patients in a perinatal clinic when the two parties do not share a native language?

Considering the two basic purposes for communication proposed by VanPatten (1998), social-psychological and cognitive-informational, it was clear that in the medical setting in which this study was conducted there was a greater need for the latter simply because of the nature of the health care professionals’ work in the clinics. They were
most often “ask[ing] questions and process[ing] language in order to get information about” (Van Patten, 1998, p. 928) the patients’ medical history and current pregnancy. For some participants in the present study the social-psychological aspect of managing relationships between people was a secondary goal; however, in order to minimally do their jobs, the cognitive-informational aspect of communication was essential.

Kormos (1999) echoed the arguments of many who have written on oral proficiency testing in her suggestion that most oral proficiency exams function as interviews instead of conversations and therefore would emphasize more cognitive-informational purposes of communication while neglecting the social-psychological elements of a conversation. While it may be true that traditional language students should be assessed on more general conversation skills, current oral proficiency testing may be well suited to working health care professionals who need Spanish to interview patients.

The patient interviews that began every patient’s visit to the clinics at times reflected the stereotypical dichotomy of either not being able to communicate or being able to communicate. Beth, a clinic nurse, described one extreme of this dichotomy in terms of her inability to understand: “I can’t get any further than either you say ‘yes’ or you say ‘no’ and that’s it” (interview 1, 328-329). A straightforward ability to communicate was reflected in the patient interview that took place at the beginning of each visit for every patient. Most of the nurses were able to ask the following yes/no questions fluently in English as well as in Spanish: “are you having swelling, are you having headaches…visual disturbances, nausea, vomiting, is your baby moving, are you
having any pain, are you having any problems, are you having contractions,…are you
having any bleeding?” (Beth, interview 1, 89-93). Other questions and statements from
the initial interview that could usually be communicated fluently included: “flujo
vaginal,…está tomando las vitaminas…necesita más vitaminas, necesita cupones de
WIC?” (week 2, 1083-1111), “por favor, su peso” (week 2, 438), “puedo checar su
presión?” (week 5, 328), and “nos ha dado la muestra de orina hoy?” (Gretchen,
interview 1, 1133) [vaginal discharge, are you taking your vitamins, do you need more
vitamins, do you need WIC coupons?…your weight, please, can I check you blood
pressure, have you given us a urine specimen today?] (see Appendix H). However,
beyond the basic cognitive-informational uses of Spanish to interview patients at the
beginning of each visit, communication was more complicated than a simple ability or
inability to communicate.

From the earliest visits to the clinic, there were three obvious types of
communication between the English-speaking health care professionals and their
Spanish-speaking patients: unable to communicate, able to communicate, or aided
communication through an interpreter. Through the data collection and analysis, it
quickly became apparent that all communication in the clinic setting did not fit neatly
into one of the three categories. An inability to communicate might have been
punctuated by understanding a word, phrase, or name. Likewise, a successful
communicative exchange might have been punctuated by an inability to convey
messages, especially when the patient had more than a yes/no response to an inquiry.
Even when present, the interpreter was not always a factor in enabling communication
between the health care professional and the patient. The professional sometimes was able to understand the patient and sometimes able to understand the interpreter. There were also breakdowns in communication with an interpreter present. This framework of communication is summarized in Figure 4.1. In the rest of this section, the nuances of an inability to communicate, an ability to communicate, and aided communication are discussed.

Figure 4.1 Communication in the clinic setting
4.3.1 Unable to communicate

The researcher collected the least data on the failure to communicate in the clinics because her role as a participant observer meant that her presence as an interpreter would facilitate communication in such circumstances. In general, the presence of interpreters in these clinics meant that a complete inability to communicate did not persist. The nutritionist cited an example from another work setting that did not have interpreting services in which frustrated English-speaking professionals resorted to talking louder and louder to Spanish-speaking clients. According to the nutritionist, their frustration also produced antagonistic body language, which further impeded communication.

Occasionally, a patient’s lack of motivation to attempt to communicate using her limited English and the health care professional’s Spanish rendered the two parties unable to communicate. One nurse said that such situations were “so seldom” (Bernice, interview 2, 63) that it was rarely a factor for her. The nurse midwife also mentioned occasional encounters with patients who demonstrated a “refusal to understand any English” (Nancy, interview 1, 240-241). These infrequent hindrances to communication will be discussed further below in the answer to question six.

An inability to communicate was evident when the patient’s English together with the health care professional’s Spanish was not enough to enable communication. Nancy, the nurse midwife, realized how important having some skills in the other’s language was when she encountered a patient who did not know any English (week 6, 398-401). Even when both parties did have enough skills in the other’s language to share some basic information, they could not always complete the communicative transaction.
For example, a charge nurse enlisted the researcher’s help to complete a phone call. She had enough background knowledge and enough understanding of Spanish to ascertain that “this is the patient who came in this morning with a rash…And we sent them to the emergency room” (week 2, 136-138), but she was unable to understand the man’s English well enough to determine what had happened at the emergency room: “and he said (pointing to the phone) ‘the doctor said…,’ then I can’t understand (raising her hands palm up on either side of her and shrugging her shoulders) anything else with his accent” (week 2, 138-141). In another instance, a patient called to make an appointment with the nutritionist, but hung up when the person who answered did not speak Spanish. When the patient came in to the clinic to try to see the nutritionist without an appointment, the nutritionist confirmed that someone had called earlier trying to communicate, but hung up. She readily agreed to see the patient without an appointment (week 4, 911-920).

The inability to communicate effectively often reflected the importance of details. The researcher was called to assist a nurse who was “trying to explain con-cep-tive” (week 1, 548) to a Spanish-speaking patient. While she remembered three syllables, the important prefix, “anti-,” was missing from her explanation of contraception. In another instance, a nurse midwife was trying to get information on a patient’s visit to the hospital and thought she had understood the patient saying “yesterday” [ayer]. The researcher asked the patient and clarified that she had said “there” [allí], indicating that a test had been done at the hospital, but that she had not been to the hospital the day before (week 6, 405-408). One nurse characterized her attempts to overcome such miscommunication as
“trying to be a little bit more careful to make sure that...what they’re saying is what I think they’re saying” (Beth, interview 2, 11-13).

Often the quantity of details impeded communication. A typical encounter between a social worker and a patient with a newborn baby included a referral to a caseworker, an explanation of information on assistance for hospital bills, payment plans for other bills, the baby’s health insurance information, and payment of the baby’s bills, with all of their attendant paperwork. On one occasion, after interpreting for a social worker and a patient, the social worker confided that the same information had been covered with another interpreter and the same patient two days before, but the patient had no recollection of the important details (week 5, 899-915).

As in the above example of the nurse’s frustrated telephone conversation with a patient who had been to the emergency room for treatment of a rash, the details of a patient’s response to a health care professional’s question beyond “sí” or “no” often represented a breakdown in communication. This issue of the health care professionals’ need for increased receptive skills will be discussed at length in the answer to question four.

Cultural issues and attempts at social-psychological communication might have further impeded communication between English-speaking health care professionals and their Spanish-speaking patients. For example, when a nurse used a Spanish translation of an English question, the intended meaning might have been lost in translation. The classic example from this study was the question “fue al baño?” for the English “did you go to the bathroom?” English-speaking patients understood the question to mean “did
you already give a urine specimen?” while the euphemism was often lost on Spanish-speaking patients, even if they understood the literal meaning of the question in both English and Spanish. This and other examples of language-specific cultural miscommunication will be discussed below in the answer to question five.

Similarly, attempts to engage in social-psychological communication sometimes increased the risk of a breakdown in communication between English-speaking health care professionals and their Spanish-speaking patients. In the above example of the nurse trying to ensure that what the patient said was what she thought they said, she was specifically referring to a breakdown in communication that probably resulted from an earlier attempt to engage in social-psychological communication. The patient had a friend with her that day at the clinic. The nurse had made an early inquiry about the friend’s pregnancy, and then when the nurse began to conduct the patient interview, the patient’s answers reflected her friend’s symptoms instead of her own. The miscommunication was easily rectified in the exam room where an interpreter was present, but the attempt to make a friendly inquiry combined with the nurse’s fluency in conducting the interview resulted in unsuccessful communication. This apparent mismatch between the health care professionals’ productive and receptive abilities will be discussed in greater detail in the answer to question four.

4.3.2 Able to communicate

All the participants in the present study mentioned interpreters as an important resource in enabling communication with Spanish-speaking clients (Beth, interview 1, 209-210; Gretchen, interview 2, 182-183; Bernice, interview 2, 27-86; Nancy, interview
However, often the interpreter was used only to facilitate ongoing communication between the health care professional and the patient. This use of the interpreter was manifested in two ways: chunking and using the interpreter as insurance.

Individually, each participant had developed the same strategy of chunking their encounters with Spanish-speaking patients so that they could call on the interpreter only at the end of their interaction. In her first interview, Bernice offered, “I’ll ask the questions I can and then I’ll store the few items that I feel like we didn’t really resolve and I’ll go get someone” (431-433). Likewise, Beth said, “I try to get through an interview with the patient as much as I can, am comfortable with, by myself and then if I have anything more than just the basic questions that I know I can handle, I…save all that for last, then call the interpreter” (interview 1, 212-215). Kim said, “I find myself not getting an interpreter—trying first and then when I come to a block” getting an interpreter (interview 2, 22-23). Nancy, a nurse midwife, said “when I’m going to use an interpreter, I will go in and actually do part of the exam myself, without an interpreter, and explain to the person that I will bring somebody in…after I finish the exam….And then [I] bring somebody in and…we talk about…my findings from the exam and…other things that we need to discuss” (interview 1, 139-151). This use of chunking was evident in fieldnotes as well as interviews. In week two, after asking a patient in Spanish about swelling and bleeding, a nurse looked across the hall to the researcher and said, “I need a little help” (270). Twice on the same day in week five, the researcher was called on to follow-up with Nancy and patients she had already examined. In one case, Nancy just wanted to
ask if the patient had any questions that had not been covered in the exam (489-491) and in another wanted to confirm some information from the exam in addition to soliciting questions or concerns from the patient (414-420). In week seven, the researcher interpreted for Nancy and a patient after Nancy had ascertained that the patient was complaining of itching. The researcher helped establish that Nancy would do an exam to determine the plan of care.

Using the interpreter as insurance was a less common practice. Three of the participants, Bernice, Kim, and Gretchen, freely used Spanish with patients in the researcher’s presence in order to improve their Spanish. Only Bernice regularly invited the researcher to sit in on portions of patient encounters in which she was not sure she would need interpreting. She likened it to having a personal trainer—“a personal listener and speaker” (interview 3, 431-433). Two representative examples follow. In the first week of data collection, Bernice asked a patient in Spanish if she was going on the hospital tour on Sunday. The patient replied, “no sé. No me llegó el papel” (90). Bernice turned to the researcher to confirm, “She didn’t get the paper?,” before proceeding to explain the hospital tour in Spanish. The following week, a patient asked if there was a children’s clinic near the clinic Bernice was describing and Bernice looked at the researcher and asked, “do they bring babies?” The researcher clarified that the patient asked if there was a clinic for babies and Bernice turned back to the patient and said “yeah, en el mismo edificio” [in the same building]. Bernice also took advantage of the researcher’s presence to go beyond the cognitive-informational purposes for communication. While taking a patient’s blood pressure in week five, she asked “Usted
siente sola para México?” and immediately followed it with the English, “I didn’t say that right. Do you miss it—feel homesick?” As the researcher said “extraña” [miss], the patient nodded (335-339).

Other than interpreters, the participants reported using their own Spanish together with the patients’ English, gestures, and written resources to communicate with Spanish-speaking clients. Most often, the aforementioned methods for communication were used in various combinations. Bernice said, “everything I do, I do with gestures” (interview 2, 93-94). The researcher’s fieldnotes verify that Bernice touched body parts that she mentioned (week 1, 77-79) and pantomimed symptoms (week 1, 86-88). Both Beth (interview 1, 223-231) and Gretchen (interview 2, 640-644) mentioned giving patients written information in Spanish while also pointing out the most important information and reviewing it orally. For organizational purposes, each communication strategy will be discussed separately.

When communicating without the aid of an interpreter, rarely was it exclusively the health care professional’s Spanish or exclusively the patient’s English that enabled communication. Usually it was some combination of both. An interaction might have begun with strategic negotiation (Pica, 1994; Rubin, 1994) of each other’s language skills. Beth reported success with starting an interaction with a new patient with “ ‘I speak little Spanish,’ so they know they have to keep it simple right off the bat” (interview 2, 205-207). In her first interaction with a Spanish-speaking patient, Gretchen asked, “¿habla Usted inglés?” [do you speak English?]. When a patient answered “no” or “poquito” [a little], she responded, “yo hablo español muy, muy, muy poquito” [I speak
very, very, very little Spanish] (interview 2, 571-574). Similarly, Bernice followed a solicitation of questions from a patient with a disclaimer: “¿Preguntas…preguntas fácil*? [questions…easy questions?] Just little phrases?” The patient giggled at the request for easy questions and said no (week 6, 85-86). In another instance, while weighing a patient, Bernice asked if she spoke English. When the patient said she spoke a little, Bernice pointed to the patient, said “poquito inglés,” then pointed to herself and said, “poquito español” (week 7, 48) to establish that they would each have to use the little that they knew. When Bernice ascertained that a patient did speak some English during an interaction, she might suggest that they both practice each other’s language. Once, to a patient and her husband, Bernice said, “Ustedes solo hablan inglés para practicar y yo solo hablo español para practicar” (week 6, 269-270).

This constant negotiation of communication had many manifestations that all resulted in mutual understanding. In the following example, the patient understood enough English to help Bernice continue communicating in Spanish:

Bernice: (holding up thermometer sheathed in disposable plastic) I don’t know how to say… (sticking out tongue)
Patient: lengua [tongue]
Bernice: No, but… “under”
Patient: abajo
Bernice: Oh, you speak English?
Patient (nodding): Un poco (indicating with thumb and index finger)
Bernice: A lot?
Patient: No. Un poquito. (week 2, 623-631)

The opposite might happen as in the following interaction in which Bernice used English that a patient did not understand and had to modify her message (Gass, 2000; Pica, 1994):

Bernice: Do you wanna try to hear the baby?
Patient looked at researcher.
Researcher: She didn’t get it.
Bernice: Oh. OK. Let me try again. Vamos a escuchar el corazón del bebé. ¿Quiere? (week 5, 1220-1224)

For the most part, the health care professionals were aware of their negotiation of linguistic resources with the patients, thus demonstrating their metacognitive knowledge. Nancy characterized the ability to meet each other half way as “fun,” adding “their English might not be really strong, but they have some and my Spanish isn’t really strong, but I have some [laughing] and so we can…put it together” (Nancy, interview 2, 546-551). The possibility of risking embarrassment to meet half way was worth it to Nancy, reasoning “that if I sound silly, but I’m willing to do it anyway, then I figure well maybe they are—that’ll make them more willing, too” (Nancy, interview 1, 334-336).

The researcher documented the following interaction in which Nancy and the patient clearly understood each other, though they each spoke in their native language:

Nancy: Have you had any contractions?
Patient: No.
Nancy: Any?
Patient: No, nada.
Nancy: Have you had any tightening on your belly? (as she measured the belly with paper measuring tapes they use).
Me: ¿Se apreta la barriga?
Patient: Sí, un poco.
Nancy: A little? Okay. Those are contractions (week 2, 41-50).

A similar interaction occurred between another nurse midwife and a patient when the researcher was unnecessarily present to act as interpreter. The nurse midwife said “just pants and panties” as she walked out the door and the patient nodded to the research to indicate that she understood (week 4, 1493-1495).
In the quest to meet halfway in communicating, it might just as well have been the health care professional speaking Spanish and the patient answering in English:

Kim: Es tu identificación por el programa. (handing her the yellow identification card) Firme aquí. Escribe uno o dos otra persona for coupons—los cupones—su esposo, su hermana.
Patient: My baby, no?
Kim: No (week 5, 281-284).

The health care professionals in this study also depended on a mixture of English and Spanish to get their messages across. Sometimes the mixture of the two languages manifested in the expression of one idea in one language and another idea in the other language. In such cases, English was used to convey incidental information:

• “Oh, you dilated a lot. Tuviste las culturas de 9 meses?” [did you have the nine-month cultures?] (Bernice, week 4, 1083)

or information that could be expressed through gesture or use of visuals:

• “No todas las puertas abiertas en la noche. Es posible solo las puertas en emergencia. And you have to go…” (drawing on map) (Bernice, week 2, 107-109),
• “¿Está lista para ser mami de dos? Let me get your weight” (indicating scale with right hand) (Bernice, week 4, 762 – 763).

Sometimes the same idea was repeated in both English and Spanish: “what is baby’s name? Nombre de bebé?” (Kim, week 1, 624), “otros? Other medicines?” (Beth, week 4, 362), “whatever God gives us. Que Dios…” (Bernice, week 4, 779), “we have a social worker, una trabajadora social” (Bernice, week 6, 477).

Most commonly, the health care professionals codeswitched in the middle of a sentence. Sometimes this codeswitching was because the professional did not know a Spanish word, as in the following examples:

• “hand goopy, frío” (week 1, 156)
• “We’ll see you in una semana” (week 1, 162-163)
• “I’ll say, ‘menos cinco libras…since última cita’” (Nancy, interview 1, 696-697)
• In the exam room with another patient, Nancy says “menos 4 libras since la última cita.” (week 3, 51-55)
• “Did you pecho baby (putting her hand on her chest).” (week 2, 400 – 401)
• “Necesita un weight. Bebé’s peso. Follow me.” (week 3, 494)
• “Come pan, cereal [pronounced like English] before you get out of bed and no líquidos” (week 4, 232-233)
• “I’m gonna get your peso” (week 4, 67)

At other times, a professional might codeswitch because she knew the patient with whom she was interacting understood English, as in the following examples:

• “N_____ is feeling más o menos today” (to interpreter) (week 2, 440-441)
• “más o menso ocho to five. Call us for anything and if we’re not there, call el centro” (reviewing the phone numbers) (week 5, 1216 – 1218).

In reflecting on the relative success of communication with Spanish-speaking clients, Nancy drew a comparison to patients from other language backgrounds. She said “if you go into a room with somebody…who speaks not a word of English….And you don’t speak a single word of their language…you can’t get anywhere….So you realize that even a little bit of language actually goes a very long ways” (Nancy, interview 1, 719-732).

Both Bernice and Nancy mentioned using “sign language” to communicate with Spanish-speaking patient, by which they meant gestures. Bernice said, “everything I do, I do with gestures” (interview 2, 93-94), while Nancy noted, “I find I move my arms and hands a lot. I use a lot of sign language or pointing to body parts when I need to” (interview 1, 167-169). Beth talked about consciously using gestures in lieu of language when trying to document a patient’s back pain: “we point, like ‘aquí’ or ‘aquí’—up or
down--and I’ll have them point to where it is and then that helps, even though I didn’t say ‘is it up high or is it...low?’ We point and I can figure it out” (Beth, interview 1, 335-339).

Whether or not they mentioned consciously doing it, as Bernice and Nancy did, all the health care professionals in the clinics made frequent use of gestures to communicate their messages to Spanish-speaking patients. One nurse recommending rest pantomimed lying down by tilting her head to the left and putting her hands together on her left cheek (week 2, 266-267). Kim put her hand, palm down on her chest just above her breast to ask if the baby was breastfed, while she said “did you pecho baby?” (week 2, 400-401) and the patient and her husband both understood. Gretchen instructed a patient in the use of medication by getting it out of the box, opening the tube, pantomiming breaking the seal, screwing the plastic syringe onto the tube, pantomiming squeezing the tube to fill the syringe, and pantomiming emptying the contents of the syringe (week 5, 92-98). Two weeks earlier Bernice (week 3, 77-81) had made a similar presentation of the same medication.

In the clinics written resources were used either to convey information to the patients in writing or as resources to facilitate oral communication with the patients. In her second interview, Gretchen explained how she used written resources in combination with her limited Spanish and gestures. She presented the patient with the written information and said, “lea esto” [read this], then she observed the patient reading it, and “bracketed” the most important sentence by pointing to it. Finally, she asked, “comprende?” [do you understand?] (interview 2, 164-168). Beth, in her first interview,
described the same strategy of providing written information in Spanish and pointing to the most important part (223-226). In her third interview, Bernice mentioned that she enjoyed reading about the strategy employed by Gretchen and Beth. As she spoke, she realized she used the same strategy—pointing out written information relative to the patients’ conditions, or explaining the children’s clinics and circling the one nearest to the patient’s home (72-88).

Throughout the clinic, prepared fact sheets were widely used to communicate with Spanish-speaking patients (Kim, interview 2, 275-280). In the early weeks of the study, the researcher collected the fact sheets as they were distributed to patients (week 1, week 2, week 3). In one representative interaction, the researcher observed Bernice giving three fact sheets to one patient. The fetal movement count fact sheet consisted of one paragraph at the top of the page that explained the importance of consciously counting eight fetal movements in one hour twice each day. The rest of the page was filled with an empty three-column table that the patient could use to keep track of the fetal movement count. The general information on family planning was an 11x17 page folded to make a four-page fact sheet. It was published by a pharmaceutical company. Bright orange stripes highlighted each birth control method and there was a black-and-white drawing of each device next to a three to six paragraph explanation of the method, how it was used, and the advantages and disadvantages of each method. The pink half sheet of paper that stated “Usted puede tomar estos medicamentos durante su embarazo” [you can take the following medicines during your pregnancy] contained a bulleted list of
four medicines—Tylenol, Robitussin DM, Sudafed, and Tums—and the symptoms for which each medicine could be used (week 2, 606-644).

A frequently expressed concern of the health care professionals when using fact sheets in Spanish or English was the literacy of their patients (Beth interview 1, 228-229, 238-240; Gretchen, interview 2, 170-173). It was this concern that had led Beth and Gretchen to combine the use of the fact sheets with simple explanations and pointing to the essential information. In week one, Bernice and the researcher consulted on the difficulty of a letter sent to confirm hospital tours. The writing style was formal, making the opening of the letter difficult to decipher for someone with limited education. It read, in part, “esta carta sirve como confirmación de su matrícula y para recordarle que la visita en que Ud. se inscribió es para lo siguiente: El horario de su clase es:" [this letter serves as a confirmation of your registration and to remind you that the tour you registered for is the following: the schedule for your class is:] The essential information that followed was exclusively in English. It listed a “Spanish Maternity Tour,” stated, “class meets: 0400-P beginning on,” —information that was difficult to decipher as an educated English-speaker—and said that the class fee was “n/a”--an abbreviation that did not make it clear that the tour was free. The letter concluded with full sentences in Spanish describing parking, where to meet, the duration of the tour, and a lengthy explanation that concluded with the statement that children were prohibited—all information that could have been conveyed simply using a bulleted list like the one on the Health Department list of safe medicines to use during pregnancy.
In addition to providing prepared fact sheets in Spanish to patients, the health care professionals sometimes used those same fact sheets as references to facilitate oral communication with the patients (Bernice, interview 1). In addition to the sticky notes and scraps of paper with Spanish words and phrases hanging in various strategic locations throughout the clinics, the health care professionals also prepared lengthy lists of commonly used Spanish language. When she started her present job, Beth filled both sides of a 3x5 index card with the initial interview information in Spanish on the left and English on the right. On one side, she fit twenty-seven questions and vocabulary items. These included the basic initial interview items that consistently enabled communication between nurses and Spanish-speaking patients listed and discussed at the beginning of section 4.3. While conducting research in the clinic, the researcher also produced a similar list of postpartum interview questions (Appendix I) and an explanation of the Women, Infant, Children nutrition program (Appendix J) for the staff to use.

4.3.2.1 Interrupted communication

Despite the language skills acquired by and the resources available to the health care professionals in the clinics, communication with Spanish-speaking clients was frequently disrupted. As discussed above, the participants in this study had developed some techniques for dealing with inevitable disruptions in communication, most commonly dividing the interaction so that an interpreter could be called in at the end to clarify or complete the communication. Sometimes using English pronunciation rendered a Spanish word incomprehensible to the patient. In one interaction, Kim applied English pronunciation to the cognates, “cereal” and “vegetables,” (week 4, 232-
which interfered with the patient understanding her recommendations. Lexical gaps in a professional’s knowledge, such as the examples of codeswitching given above, might impede the conversation. In one interaction, Kim was taking advantage of the interpreter’s presence to learn new vocabulary, but stopping to ask how to say certain words disrupted the flow of conversation. When a patient asked if she could list her baby as a WIC recipient, Kim replied, “no, es neces…how do you say ‘adult?’” (week 5, 285). In explaining the food available through the nutrition program, she said “jugo de líquido o—how do you say ‘frozen?’” [frozen juice or...] (week 5, 295).

The most common disruption in communication occurred when a participant in a conversation misjudged her interlocutor’s second language skills, specifically listening skills. In her second interview, Gretchen blamed such misunderstandings on the fact that she had mastered the initial interview questions: “I launch into my script so they think I know more than I do” (575-576). Nancy also talked about the fact that her improvements in speaking sometimes misled her patients: “I’ve learned a little bit more in the speaking than the listening realm. And I’ve found that sometimes…if I’ve gotten pretty good with several lines, then sometimes somebody will give me this real long, involved answer [laughing]. And I’m thinking, ‘they really think that I knew enough to understand all that.’ But I don’t at all. It’s just too much” (interview 2, 40-46). In observations, the researcher noted coherent, well-spoken Spanish, such as “si hay un problema con el examen de sangre, te llamamos” (week 4, 1064-1065) [if there’s a problem with the blood test, we’ll call you], triggering patient replies that included long comments and no
questions, yet the nurse became confused and sought an interpreter, explaining, “She said something and I didn’t understand” (week 4, 1067).

Nancy was careful to point out that the same problem can result from an English-speaker misjudging the receptive skills of a native Spanish-speaker based on her production (interview 2, 54-56). Bernice tried to use English as much as possible with patients who she thought could understand, but sometimes it was “too much” for the patient. In one instance, she offered the patient a paper that explained fetal movement counts. The patient looked at the researcher and said in Spanish that she did not understand. Bernice was able to re-phrase her statement in Spanish (week 5, 439-443). That the apparent gap between productive and receptive abilities seemed to widen as the health care professionals learned more Spanish provides a challenge to language educators accustomed to traditional classroom or immersion language learning experiences. This issue will be addressed further below.

4.3.3 Aided communication

As discussed above, interpreters were often used as an adjutant to enable communication between English-speaking health care professionals and their Spanish-speaking patients. At other times, the interpreter functioned in the traditional interpreter role—repeating in Spanish what the health care professional said in English, then repeating the patient’s Spanish response in English. This aided communication took place for staff who did not attempt Spanish and always used an interpreter, with staff who had saved certain parts of their interaction to cover with an interpreter, in situations in
which Spanish-speaking patients had a lengthy response to a staff member’s question, and when the interpreter herself or a patient included the interpreter in the interaction.

The staff who always used interpreters without attempting any Spanish beyond a few isolated words included one nurse practitioner (week 1, 148-164; week 3, 455-466; week 4, 534-544; week 5, 223-237; week 5, 457-487, 589-599; week 7, 275-281), one nurse (week 3, 10-49; week 4, 525-531, 1422-1468; week 5, 117-158), two doctors (week 1, 201-220, 239-260; week 6, 175-197), two social workers (week 1, 500-543; week 3, 558-572; week 5, 899-915), various medical students (week 1, 201-220, 239-260; week 6, 175-179), and laboratory and desk staff (week 4, 478-491). Each of the two doctors worked in the clinics only one morning a week—one on Wednesdays and the other on Thursdays. On Thursdays the doctor had two to three different medical students rotating through rounds with him. The doctors, and especially the medical students, were not full-time staff in the clinic so there were fewer opportunities for them to try to use Spanish.

There was a pattern to the types of information that would exhaust the staff’s Spanish language abilities and therefore be saved to cover with an interpreter. These tended to fit into the following three categories, the details of which follow:

• topics of importance to the patient’s plan of care, such as financial and administrative information that was needed to allow access to programs and assistance, postpartum issues, and following-up after an exam had already taken place,
• topics that required an in-depth explanation on the part of the staff member, such as the fetal movement count, the alpha-fetal protein (AFP) test, and sometimes birth control,
• or topics that involved a lot of dialogue with the patient, which occurred when there were complications in the initial interview.

The nutritionist and social workers often needed administrative and financial information in order to enroll the patients in the nutrition program or apply for financial assistance to pay hospital bills and get insurance for children. These interactions were often complicated by the fact that patients did not have the necessary information with them, requiring another appointment to return to the clinic. The nutritionist needed to verify infants’ date of birth and parents’ income in order to ascertain whether patients and their children qualified for the nutrition program. Therefore, interpreters had to explain that patients had to provide an official record of the infant’s date of birth and either check stubs or a letter from an employer that indicated the family’s income (week 1, 598-605; week 2, 544-574; week 4, 190-213). With the social workers, interpreters helped patients fill out forms indicating their monthly expenses (week 3, 558-572), and explained how to handle the various enrollment and billing paperwork involved in paying for care before and after receiving the newborn babies’ health insurance information (week 5, 899-915).

Postpartum visits posed a challenge to the nursing staff because they required finding out what had happened at the hospital, where there was not always an interpreter, and inquiring about the mother and baby’s health since the baby had been born. For example, Bernice was able to ascertain that a patient had received an injection in the
hospital, but the patient did not know if it was a vaccination or a birth control injection. Bernice required an interpreter to describe the differences in the two injections to try to determine which it was (week 5, 261-267). In another postpartum visit, the researcher clarified the procedures for the birth control method the patient had chosen and discussed with the patient how and where to continue to receive medical care (week 1, 371-412)—both topics which lay outside the routine of the prenatal care provided at the clinics. In yet another postpartum visit, the nurse was unable to determine the following: why the patient had had a Cesarian delivery, whether the patient was breastfeeding—the baby had trouble latching on and the patient’s milk had since dried up, and what birth control method the patient had chosen. The patient being under eighteen years of age further complicated the provision of birth control (week 2, 327-385). In one interaction, Beth called on an interpreter to explain how to acquire birth control after the postpartum visit, when the perinatal clinic would no longer serve the patient (week 4, 390-403). As the above examples demonstrate, there was less of a pattern for the health care professionals to follow in communicating with patients in the postpartum interviews as compared with the initial interviews at the prenatal visits.

Nancy, the only practitioner participating in the study, regularly used interpreters to follow-up with patients after she had examined them. Nancy used the interpreter to ensure that she and the patient had understood each other during the exam and to provide the patient an opportunity to ask any questions she had. Typically in the follow-up interactions, Nancy would clarify important issues such as whether the patient had had any contractions (week 2, 45-50; week 4, 416-434), how far dilated and effaced the
patient was (week 4, 712-722), how to know when to go to the hospital (week 4, 712-722; week 5, 489-515), how to proceed when the patient was past due (week 4, 416-434; week 4, 712-722), and how to treat a collateral medical problem (week 4, 1148-1155; week 5, 489-515; week 6, 196-212; week 7, 202-215, 283-319). Nancy always gave the patient an opportunity to speak through the interpreter, asking, “any questions or concerns?” (week 1, 143-146; week 4, 429; week 5, 415-416, 489-515).

Like Nancy’s follow-up interactions with the patients that required an interpreter, the nurses also encountered topics that repeatedly required in-depth explanations: the alpha-fetoprotein (AFP) screening, the fetal movement counts, and certain questions related to birth control. AFP screening was an optional blood test that could determine an increased risk of having a baby with open spine or Down’s syndrome. A positive AFP usually led to further tests, which may or may not have confirmed one of those two birth defects. Because the patient had to decide whether to have the AFP screening and because the results could cause a lot of unnecessary anxiety, the staff was always careful to ensure that the patient understood the procedure (Bernice, interview 2, 183-186; week 5, 122-127; week 5, 1148-1153). As discussed above in section 4.3.2, there was a fetal movement count fact sheet in Spanish, but the details of what to do when one did not count eight fetal movements in one hour were complicated. Nurses called interpreters to explain that the patient should drink water, lie down on the left side and count for a second hour and if there still were not eight movements, go to the hospital (week 2, 356-385; week 2, 727-734; week 2, 1091-1099; week 4, 717-719; week 4, 1637-1654; week 7, 154-158). In one such exchange, Beth added the comforting information that
“normally, if you do go to the hospital, they wake the baby up and everything’s okay” (week 2, 1098-1099). Though there was ample literature on birth control available in Spanish, two new methods had been added since the birth control literature had last been updated. When a staff member had to explain one or both of those methods to a patient (week 1, 551-558; week 6, 140-145) or when a staff member had to explain the actual use of any birth control method to a postpartum patient (week 1, 371-381; week 2, 356-385; week 4, 390-402), she often used an interpreter.

The other circumstance in which staff consistently required an interpreter was when the patient response to an inquiry was more complicated than “yes” or “no” (Bernice, interview 2, 323). As Beth said, “If I get anything more than a ‘yes’ or a ‘no,’ then I have to go find the interpreter” (interview 1, 98-100). In one instance, when asked, “do you need more vitamins?” the patient replied that the vitamins made her sick and she threw up everything she ate, even though she had tried taking them at different times of day (week 2, 308-310). Such a response during the initial interview exceeded the listening abilities of the nurse conducting the interview, even if she could normally conduct the initial interview without an interpreter. In another case, Bernice asked a patient the standard interview question about the baby’s movements and needed an interpreter when the patient began to describe her visit to the hospital because the baby had not been moving enough (week 2, 727-741). When scheduling appointments outside the clinic, the charge nurses might have used an interpreter in order to understand the patients’ availability, which might have included days available, days unavailable, and times of day that could be understood in isolation, but not put together with confidence.
by the charge nurses (week 5, 548-557). Similarly, it was sometimes possible to understand that a patient had a pain (week 7, 126-154) or a question about spicy food (week 7, 218-226), but an interpreter would be needed to understand the nature of the pain or the question about diet in order to be able to respond properly.

4.3.3.1 Aided unassisted

There were times when an interpreter had been called to interpret and was indeed interpreting and an exchange would occur in which the interpreter was not needed. Often this was when the health care professional produced single words or memorized phrases or when the patient understood the professional’s English. In one instance a doctor was able to ask a patient many of the initial interview questions that the nurse had already asked and only needed the interpreter to help with pronunciation and interpret when the actual exam began (week 1, 201-220). During another exam, a practitioner asked “is she taking Tylenol for the headaches?” and the patient immediately turned to the researcher and said “sí” (week 3, 249-252).

For the purposes of this study, the focus on unassisted communication punctuating an interpreted interaction involved the health care professionals’ ability to understand spoken Spanish. Sometimes it was the patient they understood and sometimes it was the interpreter. When they understood the patient it was usually a yes/no answer or a short answer with familiar language. At other times, they were taking advantage of having an interpreter present to guess. For example, the interpreter asked if a patient was breastfeeding, the patient answered, “sí” and the nutritionist asked the next question in English, “breastfeeding only?” and the patient again answered, “sí” (week 1, 249-252).
In a similar case the patient asked if the patient was experiencing tightening in the belly, the patient answered, “sí, un poco,” and the practitioner immediately replied in English, “a little? Okay. Those are contractions” (week 2, 47-50). In another case the same practitioner had asked the patient if she knew when to go to the hospital, the patient said “cuando me rompa la fuente, si hay sangre, dolores” [when my water breaks, if there’s bleeding, pains]. Without the interpreter, the practitioner added “and contractions three to five minutes apart” (week 5, 493-500).

When the patients’ replies were more than simple, familiar words, the health care professionals checked that they understood correctly with the interpreter before replying, as in the following examples:

Patient: No sé. No me llegó el papel. [I don’t know. I didn’t get the paper.]
Bernice (to researcher): She didn’t get the paper? I’m guessing (week 1, 90-91).

Patient: No, la dirección se ha cambiado otra vez. [No the address has changed again.]
Bernice: Changed? I got “cambia.” That’s the only word I got (week 1, 101-102).

Bernice: Does she need to take proof of income to the hospital?
Researcher: Yes.
Bernice: Entiendo! [I understand] I don’t know. That’s a question for A____. Es una pregunta para la trabajadora social (week 4, 499-502).

Bernice: I think I got it. Her friend gave her some medicine for nerves, but she doesn’t know if they were vitamins or what (week 6, 1157-1158).

Patient: el 19 de este mes, va a cumplir 2 años [the 19th of this month, she’ll turn 2]
Social worker: she’ll be two? (week 7, 63-65).

When the health care professionals understood the interpreters it was either a case of them understanding their own words repeated in Spanish or the content well enough to know that the interpreter was wrong or had left something out. This was particularly an issue when the interpreter had become familiar enough with the information to be
confident enough—perhaps overly so—in her knowledge of a topic to address it without actually having the health care professional say everything first in English. For example, a nurse gave the researcher written information on clinics where a patient could continue to get care after her pregnancy and simply asked the researcher to explain it. After the researcher’s explanation, the nurse, noting that the researcher had not opened one pamphlet, asked, “did you tell her about the Neighborhood Health Centers?” (week 1, 395-402). In an exam, the researcher repeated the practitioner’s question, asking the patient why she was supplementing breastfeeding with formula, but added that it did not matter that she was doing so since she just wanted to know why. The practitioner understood enough to clarify that the birth control pill she might recommend would only work if the patient were exclusively breastfeeding (week 1, 45-49; Bernice, interview 1, 347-365). Bernice shared two instances of a similar misunderstanding with interpreters who were explaining group B strep infections to a patient and mentioned the possibility of the baby getting an eye infection. Bernice recognized that the interpreter was confusing it with another infection and clarified (interview 1, 400-411; interview 3, 444-449).

4.3.3.2 Aided interrupted

The interpreter’s presence did not always ensure successful communication between health care professionals and patients. The interpreter might have misunderstood words while interpreting or produced erroneous words that interfered with communication. The researcher experienced both of those situations in her role as
participating interpreter. The researcher also experienced misunderstood intentions as an interpreter in the clinic, but those cases were not specific to language barriers.

In a postpartum visit a patient said she was unable to get birth control at the hospital when she delivered her baby because she was “pequeña” [small]. The researcher told the nurse that the patient was unable to be fitted for the device because her body was too small, then asked the patient if that was correct, and the patient clarified that it was “porque soy menor de edad” [because I’m a minor] (week 2, 362-366). Another patient had been told in Spanish “para agruras, Tums” [for heartburn, Tums] and understood the condition, but not the remedy. She asked the researcher, “para agruras ¿qué?” [for heartburn, take what?]. The researcher understood “Tums,” but did not know the term “agruras.” Together with the nurse and patient, the issue was quickly resolved (week 6, 492-499). As with any communication, resolving the misunderstood word did not always clarify matters. In one instance the patient said she was using a product called “vaporid.” The researcher understood and wrote, “vapor,” the patient added “-id,” but the practitioner did not know what “vaporid” was (week 5, 503-509).

At times when the researcher produced the wrong lexical item, the interlocutor either made the correction or solicited a repetition. In explaining a yeast infection to a patient, an interpreter provided the word “bacteria,” a cognate word which the practitioner recognized as incorrect, saying “actually, it’s not a bacteria” (week 3, 66-71). When the researcher asked a patient if she had received intravenous medicine, she used the word “suelo” [ground], but the patient’s husband immediately provided the correct term--“suero” (week 2, 1143-1144). When a nurse said the blood should change from red
to brown, the researcher said the word for purple [morado] instead of brown. The patient gave a quizzical look and the researcher recognized her mistake and corrected it (week 2, 276-284). When going over the breakdown of expenses with another patient, the researcher pointed to the English word, “loan” and asked “gastos,” which is the word for “expenses.” The patient looked confused and the researcher corrected herself, saying “préstamos” [loans] (week 3, 568-570). Sometime the researcher caught her own mistakes, saying “cartón” for “box” and immediately realizing the word she was looking for was “caja” (week 2, 319-322), or pantomiming a word she could not remember, “needle,” while guessing “aguda?” The patient immediately provided the correct word, “aguja” (week 5, 264-266).

As the above discussion makes clear, communication in medical setting where the providers and patients have different native languages is more complex than a simple ability or inability to communication. A communicative interaction between an English-speaking health care professional and a Spanish-speaking patient may reach a point at which no further progress can be made. Likewise, a seeming inability to communicate may be overcome through the efforts of the two interlocutors. Communication may require a third party to interpret, but sometimes communication occurs without a need for interpreter intervention and sometimes interpreter intervention fails to facilitate communication.

4.4 Research question 2: In learning Spanish on the job, what linguistic structures are acquired by health care professionals?

In acquiring Spanish on the job to use in the presentational mode of communication (Klee, 1998), the health care professionals in this study primarily learned
to produce isolated lexical items and fixed expressions, with some sense of verb
conjugations—mostly in the present tense. There was a literal sense of translation in the
more complex expressions health care professionals acquired during the period of
research. Only the most advanced participant was able to create with the language.

With respect to the interpretive mode of communication (Klee, 1998), the
participants in the study understood a small range of isolated words, but rarely
understood the context of an answer that consisted of more than those words.
Participants reported that listening was easier with an interpreter present. Participants
were able to check with the interpreter in general to ensure understanding as well as
check for understanding of specific lexical items. Often the interpreter’s Spanish was a
repetition of the participant’s English, making the content familiar and therefore easier to
understand. Even when a participant understood a patient’s reply, she might not have
controlled the productive abilities necessary to ask the question that elicited the reply. In
the following two sections, productive and receptive acquisition will be examined
separately.

4.4.1 Productive acquisition

Consistent with Bearden’s (1998) assertion that vocabulary was the base upon
which other competencies developed and Shresta’s (1998) findings that vocabulary
knowledge was more useful than grammar and structure knowledge for basic
communicative purposes, all the participants in the study had acquired a vocabulary base
relevant to their daily work. Gretchen coined the term “script” to describe these basic
lexical items that the staff were able to produce. The basic script consisted of the initial
interview questions that began every visit to the clinic. The work-up, as this portion of the visit was called, began with confirming that the patient had given a urine sample, getting the patient’s weight and blood pressure and asking a series of questions about pregnancy symptoms (see Appendix H for a full list). All three nurses who participated in the study mentioned the “script” in their first interview (Bernice, 82-86; Beth 84-93; Beth, interview 2, 80-82; Gretchen, 206-210) and Kim, the nutritionist, said “we find ourselves in our own role in the prenatal clinic…sticking to the same…information” (interview 2, 542-544). In the second week alone there were nine references to the work-up script in the fieldnotes, two included the entire script as spoken in that interaction (934-955; 1067-1090). Beyond the basic script, the staff all knew some basic questions and commands, such as “ven” [come] (Gretchen, interview 2, 526; week 1, 338), “¿comprende?” [do you understand] (Gretchen, interview 2, 167), “lea esto” [read this] (Gretchen, interview 2, 165), and “espera en la sala” [wait in the waiting room] (week 7, 161-162), “calambres” [cramps], “estreñimiento” [constipation], “dolor de repente” [sudden pain = ligament pain] (Bernice, interview 1, 139-141).

The researcher developed a script for postpartum appointments (see Appendix I), which were scheduled for six weeks after the patient had her baby. In postpartum appointments, the nurse conducting the interview had to elicit detailed information about the delivery, the hospital stay, the baby, postpartum symptoms and complications, birth control methods, and follow-up care for the mother and baby. Bernice had developed a postpartum script of her own (week 3, 362-401; week 5, 255-260), but other nurses had been relying on interpreters to complete postpartum visits (week 2, 327-406; week 4,
In both her interviews and the researcher’s observations, Beth reported automatically using an interpreter for postpartum visits before the researcher prepared a postpartum script (week 4, 354-355; interview 2, 147-149). The researcher also observed Beth’s frustrated attempt at conducting a postpartum visit with a Spanish-speaking patient before the script was prepared. She began by asking ten basic questions in Spanish, then used English to ask the patient if it hurt to urinate and what birth control method she would like to use before the researcher was engaged to interpret the rest of the discussion of birth control (week 4, 358-408). In her second interview, Beth reported using the postpartum script to chunk her interactions with Spanish-speaking patients. Instead of seeking an interpreter immediately, she was able to conduct most of the interview herself and save the unresolved questions for an interpreter (136-144).

In addition to the routine work-ups, charge nurses’ responsibilities included “intakes,” a patient’s initial visit to the clinic in which her record was set-up and medical history taken, and “exiting,” a final interaction with every patient before she left at the end of each appointment to review that day’s exam and coordinate the plan of care. Intake visits lasted for at least an hour and always required an interpreter to help the patient with paperwork as well as to facilitate communication between the charge nurse and the patient. The charge nurses who participated in the study, Gretchen and Bernice, were both able to use Spanish to conduct the portion of the intake that paralleled the general work-up interview. Additionally, they were able to ask some basic questions about the pregnancy, such as “¿embarazado* primero?” [first pregnancy?], “¿tiene
vitaminas?” [do you have vitamins?], “¿Y toma una pastilla al día?” [are you taking one pill a day?], “¿cuántos vasos* de agua?” [how many glasses of water] (Gretchen, week 4, 1213-1219), “¿su embarazo fue planeado o una sorpresa?” [was your pregnancy planned or a surprise?] (Bernice, week 5, 1238). Gretchen and Bernice could both describe some of the basic written information they distributed to new patients. Bernice, for example, handed a patient a booklet and said “información sobre el embarazo” (week 5, 1168) [information about pregnancy]. The review of the patient’s medical history beyond cognate medical terms such as “anemia” and “diabetes” (week 4, 1227-1230), was usually too complicated to do without an interpreter.

Likewise, conducting exit interviews required an ability to carry out a variety of tasks. In some cases an exit interview was a matter of a quick review of the patient’s chart and a reminder of when to make the next appointment, which both Gretchen and Bernice could do proficiently in Spanish. On one occasion, Gretchen provided a patient with a bottle of pills and said, “una pastilla en la mañana. Una pastilla en la noche. Con comida” (week 5, 169-170)[one pill in the morning. One pill at night. With food]. As described in section 4.3.2, both Gretchen and Bernice were observed using gestures to explain the use of a prescribed cream during an exit interview. Bernice frequently reviewed the symptoms of labor that would require going to the hospital: “si rompe la fuente, posible rompe la fuente, si está sangrando, como menstruación o si muy fuertes dolores de cabeza…” [if your water breaks or possibly breaks, if you bleed like menstruation, or if you have bad headaches…] (week 4, 521-523). However, exit interviews often included such things as scheduling appointments for further tests at other
facilities, providing maps and directions, issuing medicine and explaining its use, and reviewing the symptoms that require going to the hospital. The slightest error in communication in carrying out those tasks could have serious ramifications and so interpreters were used for all but the most-simple exiting.

Kim, the nutritionist, had a unique script, but a script nonetheless. She was observed asking patients about their symptoms and their diet as well as handling administrative tasks involved in distributing food coupons:

- ¿Tiene vómitos? [are you vomiting?] (week 4, 226)
- ¿Cuándo? ¿Todo el día? [when? All day?] (week 4, 228)
- ¿No problemas con nauseas, vómitos, poco apetito? [no problems with nausea, vomiting, decreased appetite?] (week 5, 374-375)
- ¿Come cuántas veces al día? [You eat how many times a day?] (week 4, 230)
- ¿Consumes…. [Do you consume..]
  - leche? milk?
  - queso? cheese?
  - proteína? Huevos, carne, pollo, frijoles? protein? Eggs, meat, chicken, beans?
  - pan, cereal, tortillas? bread, cereal, tortillas?
  - fruta? Naranjas….? fruit? Oranges…?
  - jugo de frutas? fruit juices?
  - vegetales? vegetables?
- Tus cupones for dos meses. Necesita firme aquí. ¿Tiene preguntas? [Your coupons for two months. You need sign here. Do you have questions?] (week 4, 247-267)
- Necesita escribir tu nombre [You need to write your name] (week 5, 377-378)
- Tu copia (week 5, 379) [Your copy.]

The researcher worked with Kim to prepare a refined written script from which to work (Appendix J).

Because Nancy divided her exams into the part she did by herself behind the closed exam-room doors and the part she did with an interpreter, the researcher did not have an opportunity to observe patterns in her use of Spanish. However, there was a pattern to how she increased her Spanish. She started writing words and phrases in
English on Health Department letterhead that she wanted to know how to say in Spanish. She started with simple words—“gained,” “lost,” “since”—and questions—“do you have?,” “are you taking?” (week 3). That pattern continued as she added “about” and longer questions such as, “are you eating good foods?,” “are you eating 3-4 times a day?” (week 4), “are you sure of the date of your last period?,” “do you know if you will breastfeed?,” and “do you know what you would like to use for contraception?” (week 5).

Nancy began to need phrases to follow-up with, as in the following example: “If I say ‘cuentas los movimientos?’ and they say ‘sí, sí’...then how do I say, ‘keep doing it’?” (week 5, 970-972). She also started creating with the language, sometimes underlining the English where she was missing a Spanish word, as in “su cervix está ready” [your cervix is ready] (week 4, 325) and “si tiene contracciones every 3 o 5 minutos” [if you have contractions every 3 or 5 minutes] (week 5, 570-571). At other times, Nancy worked with the researcher to construct the phrase in Spanish. For example, she asked, “‘Cuentas los movimientos?’ is ‘are you counting the movements?’ so is ‘are you counting the baby’s movements?’ ‘cuentas el baby movimientos?’” The researcher explained possessives in Spanish and helped Nancy form the correct question, “¿cuentas los movimientos del bebé?” (week 3, 229-233). In another case, she had written “su cervix es no diferente desde la última sitio” [your cervix is no different since the last visit] and the researcher simply pointed out that “no” comes before “es” (week 4, 316-317). Sometimes her translations were correct, as when she asked, “So if I want to say ‘how many movements?’ that’s ‘cuántos movimientos?’” (week 4, 588-589).
Most of the verbs that the participants knew were used as part of fixed expressions so that they were not actively conjugating verbs. Beth represented the common view that for their immediate purposes in the clinics, fixed expressions were the most practical way to learn to use Spanish on the job. She offered, “I get really lost conjugating verbs” (interview 1, 414). When asked what she thought should be included in a structured course, she said “a little bit more of conjugating verbs…cause a lot of times I know what the verb is, but I don’t know how to spit it out to make it make sense” (interview 2, 404-408). However, Beth did not anticipate adding any formal instruction with her own time or at her own expense.

Nancy, Bernice, and Gretchen all expressed an interest in learning to use verbs. When asked what she thought she needed to better communicate with Spanish-speaking patients, one thing Nancy mentioned was, “maybe gradually learning some…new verbs and new conjugations” (interview 1, 609-609). She added that she preferred not to “just learning something verbatim without having some sense of how to put it together because then it makes it harder…to take those…verbs or the word or whatever, and know how to put it into other sentences” (611-614). The second part of the first interview with Nancy was largely devoted to a discussion of verbs and the best ways for her to learn them. It was agreed that the researcher would make cards with the present tense conjugation of the verb in all forms on one side and the second person formal of present perfect, preterite, and present for three verbs: ser, estar, and tener. The present tense would serve as a familiar point of reference from her formal courses in high school Spanish while the present perfect, preterite and present would allow her to communicate, “have you had,”
“did you have,” and “are you having,” in the case of the verb, “tener.” After the second interview Nancy was provided with a one-page list of the changes that occur in present tense verbs so that she might further seek patterns instead of learning each lexical item in isolation.

In Bernice’s first interview, she pinpointed verbs as a consistent difficulty. She said she often managed to communicate without necessarily conjugating the verbs correctly, but added “it would be nice to do it right” (interview 1, 726-727). She suggested “maybe someone sitting at a desk like me...like a rolodex...of...the most common verbs” (interview 1, 723-729). Bernice was speaking in general about the needs of health care professionals with Spanish-speaking patients and did not specify verbs nor tenses in that first interview. The researcher prepared a rolodex with a dozen commonly used verbs in the clinics, formatted in the same way the cards had been formatted for Nancy. It was immediately obvious to Bernice that she did not need the present tense conjugations because she struggled with past tense (week 3, 7-8). Other data bore this out, as in the first interview when she offered that she knew “fui” was “I went” and “¿fue?” was “did you go?” (734-741) and in a patient interview in which she easily moved from past to present, producing “¿recibiste...” [did you receive?], “¿el doctor te dio...?” [did the doctor give you?], “¿todavía quiere...” [do you still want?], “¿tiene...?” [do you have?] (week 6, 63-81).

Like the others, Gretchen immediately pointed to verbs as the area of greatest need, saying “those are what always get me really hung up” (Gretchen, interview 1, 267-268). In her second interview Gretchen specified four verbs that she would like to work
on using in Spanish: “to have,” “to remember,” “to know,” and “to need.” Having learned from earlier mistakes, the researcher was careful to discuss with Gretchen the format of the cards on which the four verbs would be presented. They included present tense conjugations on one side and commonly used expressions on the other. Within hours of providing the four cards, Gretchen had an opportunity to use one when asking a patient if she knew how to use a medicine. Acting as interpreter, the researcher asked the patient, “¿sabe usar una crema vaginal?” [do you know how to use a vaginal cream?]. As soon as the patient left, the researcher pointed to the card that said “¿sabe + verb = do you know how to verb?” and said “‘do you know how to use?’ is ‘¿sabe usar?’” Gretchen repeated “sabe usar” three times and said “I’ll use it three more times today” (week 5, 85-91).

Another nurse in the clinics used a similar approach to adding to her verb repertoire. After a discussion of “did you have…?” and “have you had…?,” the researcher prepared two cards for her, one for each expression. Later that day, the same nurse passed the office where the researcher was seated and solicited another verb card: “the next one I need is ‘I will’--‘I will check your blood pressure’” (week 4, 635-665).

In learning new phrases in Spanish, there was a tendency to seek word-to-word correspondence with English. In the above example, when the nurse asked how to say “did you have…?” and the researcher wrote “¿Tuviste…?,” her reaction was “that’s it? That’s all three words?” (week 4, 640) and a conversation comparing English and Spanish ensued. In her first interview, Nancy expressed a desire to fill out her incomplete sentences in Spanish. She said she put “¿tiene?” [do you have?] together with
one other word to ask “¿tiene problemas?” [do you have problems?] or “¿tiene preguntas?” [do you have questions?] without “doing all that I should to really construct a good sentence” (388) and later added that she would like to be able to say “are you having?” instead of just “¿tiene?” (1001-1002)—which can mean “are you having?” as well as “do you have?” Again, there was a conversation comparing Spanish to English and Nancy concluded, “So that’s a decent sentence — ‘tiene contracciones?’” (1015). However, later in the clinic the knowledge that a verb without a subject would not form a complete sentence in English had Nancy pursuing a “more complete” sentence than “¿tiene?” in Spanish. She suggested that “¿Tú tienes?” would make her question sound more complete (110-111). In her second interview she confirmed that she had an improved understanding of how the Spanish language differs from English and did feel confident that “¿tiene dolores?” [do you have pains?] was a complete sentence (284-287).

Nancy also struggled with the reflexive use of “se” in the expression “¿se mueve el bebé?” [is the baby moving?]. In her first interview she said, “when I learned the phrase ‘se mueve el baby’…what the heck is ‘se’?…I don’t know how to use it anywhere else. That’s part of a verb, right?” (1081-1083). Later in the same interview, Nancy asked, “when I say, ‘se mueve el baby’…does that mean ‘Is your…?’” (1158-1159) and there was a discussion of “se” being part of the reflexive verb, allowing for a distinction between something moving itself and someone actively moving something. The subject came up again in the clinics the next week. Nancy had written “se mueve el bebé?” and asked, “does this mean ‘is the baby moving?’” as she began to write “is” above the word “se.” Again, the researcher explained that “se” is part of the reflexive verb (week 3, 209-
213). To Nancy’s credit, when asked in the second interview if she was able to recognize the reflexive “se” in any other contexts, she immediately thought of “ojalá que se mejore pronto” [hopefully you’ll get better soon] (interview 2, 293).

In general there were few attempts to create with the language in the clinic setting. In trying to acquire a new fixed expression, Nancy did try to create the sentence as completely as possible herself before seeking assistance, as discussed above. Bernice was the only participant to regularly and successfully create with the language. As an illustration, the following is a list of some of the ways she introduced the researcher to patients. It was noteworthy that she consistently demonstrated an understanding of the null subject and the use of the direct object pronoun, “nos:”

- Darcy es maestra de español. Es experta en dos idiomas. Tiene un programa en la universidad para ayudar a enfermeras y otras personas en la clínica. Necesitamos mucha ayuda [Darcy is a Spanish teacher. She’s an expert in two languages. She has a program at the university to help nurses and other people in the clinic. We need a lot of help.] (week 2, 28-30)

- Mi amiga Darcy habla español y inglés. Mi amiga Darcy enseña español y quiere ayudarnos aprender español porque tenemos muchos pacientes… [My friend Darcy speaks Spanish and English. My friend Darcy teaches Spanish and wants to help us learn Spanish because we have a lot of patients…] (week 2, 606-608)

- ¿Conoce a mi amiga Darcy? Ella es profesora de español en Ohio State. Ella nos estudia. Nos* los trabajadoras para ayudarnos a estudiar español mejor. [do you know my friend Darcy? She is a Spanish professor at Ohio State. She’s studying us. We, the employees to help us study Spanish better] (week 4, 1059-1061)

- Darcy es profesora de español y está aquí para ayudarnos con español. Pero todos los días aprendes…apren…aprendemos más [Darcy is a Spanish professor and she’s here to help us with Spanish. But everyday, we learn more] (week 5, 324-326)

- Darcy está estudiando nosotros…Or I could say “Darcy nos estudia.” [Darcy is studying us] (week 5, 1059-1061).
The researcher’s notes were full of examples of Bernice creating with the language beyond an already full range of interview questions. When a patient reported “dolor en el vientre. Se pone duro” [*pain in the stomach. It gets hard*], Bernice was able to rephrase the patient complaint as a question, “¿su problema de hoy es cólicos?” [*your problem today is contractions?*] (week 3, 393-397). She used “gustar”–a verb that translates to the English, “to like,” but literally means “to please,” reversing the grammatical subject and object—in at least three ways. In talking to a patient about pelvic exams, she said, “nadie le gusta” [*nobody likes*] (week 3, 367), in talking about the new word she had learned--“cuidadosamente” [*carefully*], she said “me gusta porque es muy larga” [*I like it because it’s very long*] (week 6, 57), and in asking a patient to report the date of the baby’s first kicks, she said, “nos gusta saber el día siente el bebé pateando” [*we like to know the day feel the baby kicking*] (week 7, 56-57).

Bernice created in Spanish to communicate important information to patients, but also to engage them for social-psychological purposes. She gave a patient a bottle of medicine to take and said, “hasta que nace* el bebé,” [*until the baby is born*]. The patient asked, “¿después no?” and Bernice immediately replied, “en el hospital el doctor te dice” (week 4, 1101-1104). In trying to determine if a patient had already taken a sweetened drink that must be consumed before a glucose blood test, Bernice had the following conversation with a patient:

Bernice: ¿No tomas esa bebida antes? [*did you drink that drink already?*
Patient: No.
Bernice: ¿Es la primera vez? [*this is the first time?*
Patient: Sí.
Bernice: Porque en su orina azúcar un poquito [*because in your urine, sugar a little*] (week 5, 312-316).
In making friendly conversation with patients, Bernice created the following questions and statements:

- **¿Cómo está? ¿Está lista…that means “ready”…¿Está lista para ser mami de dos?** [Are you ready to be a mother of two?] (week 3, 761-762)

- **Yo creo que Usted recibiste* la inyección rubela. No creo que anticonceptivos porque el hospital católica*. Soy católica. ¿Y Usted?** [I think you got the rubella shot. I don’t think contraceptives because the hospital Catholic. I’m Catholic. And you?] (week 5, 255-256)

- **Let me go check for a room. Este paciente está delante de Usted y luego Usted** [this patient is ahead of you, then you.] (week 5, 351-352).

- **Mi nieta va a estar* tu novia** [my granddaughter’s going to be your girlfriend] (to a patient’s eighteen-month-old son) (week 5, 562)

- **…malo. El sabor es como…barro** [bad. The flavor is like clay.] (in a comparative evaluation of bran cereals) (week 5, 1018).

### 4.4.2 Receptive acquisition

With respect to the interpretive mode of communication (Klee, 1998), participants completely understood some isolated words when spoken alone, but rarely understood multi-word thoughts expressed in Spanish. They also reported that understanding spoken Spanish was easier than speaking, particularly when the interpreter was present.

A childbirth educator who sometimes worked in the clinic explained the point at which understanding became difficult: “you don’t need much Spanish to get how many children, did you breastfeed? It’s the nuances I need help with. I asked her in Spanish if she was planning to breastfeed and she said in English, ‘maybe.’ Well, ‘maybe.’ I need to know why? What does ‘maybe’ mean? She has to work?” (week 4, 1473-1477). In their interviews, the participants echoed the sentiment of the childbirth educator. Bernice said she could understand “as long as they don’t put it in a gigantic sentence” (interview 1,
Nancy said, “I can pick out…bits and pieces” (interview 1, 404) and “I get short answers…, but it’s more the long involved answers that are like, ‘wait a minute, that’s outside my realm’” (interview 2, 67-70). Likewise, Beth said “they might give me a big phrase or sentence in an answer and I might only fully understand one or two words out of that” (interview 1, 359-361).

The one-or-two word answers that the participants understood included:

• yes/no (Beth, interview 1, 328-329):

  Gretchen asked a patient if she was having headaches
  Patient: antes sí, pero ya no.
  Gretchen: before yes, but not anymore
  Patient: Sí (week 4, 1244-1246),

• family relations:

  Gretchen: ¿Diabetes? ¿Su mamá?
  Patient: Sí.
  Gretchen: ¿Y?
  Patient: Y la mamá de mi mamá.
  Gretchen: Your mama’s mama. So that’s maternal grandmother (week 4, 1230-1234)

  Bernice: ¿Amiga o familia?
  Patient’s friend: Es mi cuñada.
  Bernice: Sister-in-law! (week 6, 49-51)

• numbers

  Bernice: ¿Cuántos niños tienes?
  Patient: Veinte y siente.
  Bernice: No. ¿Cuántos niños?
  Patient: Tres (week 5, 320-323)

  Patient: El 19 de este mes, va a cumplir 2 años.
  Social worker: She’ll be two? (week 7, 63-64).

  Bernice (on telephone): Dame tu número de teléfono…no entiendo…más despacio (writes down phone number) (week 5, 1254-1256)
• days and time references

“I got ‘Friday afternoon,’ but then I’m getting ‘temprano,’ too. So I can’t figure it out” (week 5, 550-554)

Bernice: ¿Qué prefiere—la mañana o la tarde?
Patient: Mañana…en la mañana.
Bernice: ¿Pero qué días es* mejor?
Patient’s husband: El miércoles o el jueves en la mañana. (week 6, 261-266).

• Colors

“I know my colors so I can understand that” (Beth, interview 1, 378-379)

• common medical terms:

“sangre” [blood] (week 4, 27-28)

“cuando me rompa la fuente. Si hay sangre. Dolores” [when my water breaks. If there’s blood. Contractions.] (week 5, 498)

“It’s usually the body part that they’re naming that I’ll pick up on” (Beth, interview 1, 361-362).

The spoken single-word answers that the clinic staff understood in Spanish were consistent with the basic vocabulary taught in a traditional beginning Spanish class. The materials from the first course that Bernice and another clinic nurse took at a local Department of Parks and Recreation included days, months, and numbers in week one, body parts in week two, colors in week five, and family vocabulary in week six along with the introduction of some basic verbs and common expressions for facilitating communication each week (week 4, 930-970).

Bernice was the only participant who consistently understood more than a few isolated words of Spanish (see examples in section 4.3.3.1). In exiting a patient who had tested positive for tuberculosis with the help of an interpreter, Bernice raised her right
hand like a student in class and used her knowledge of the context in addition to her
Spanish-language knowledge to guess: “let me guess what you said! You said it’s okay
to take medicine after the first trimester and she said she was vaccinated before in
Mexico and they told her she’d test positive because of that” (week 6, 248-252). When
Bernice asked another patient if she had vitamins, the patient responded, “se me
acabaron,” Bernice guessed, “You took them all? You ran out?” The patient repeated, “se
me acabaron ayer” and Bernice concluded “you ran out yesterday.” Bernice then used
inferencing, an important listening strategy (Chamot and O’Malley, 1994), and added,
“so ‘acabaron’ is ‘all gone,’” (week 6, 480-485).

The researcher asked all the participants about the seeming contradiction between
their ability to speak Spanish more proficiently than they could understand it and their
claims that listening was easier than speaking in general. In her first interview, Beth said
“I just think understanding comes maybe before speaking…I can definitely understand a
lot more than I can say” (509-511). Nancy agreed, asking “doesn’t it happen sometimes
where people will understand more than they speak?” (interview 1, 401-402). In her
second interview, Bernice made the important observation that an interpreter’s presence
was a key factor in an improved ability to understand (interview 2, 312-313). Primarily,
the interpreter served as someone to confirm that Spanish had been understood. As
Bernice said, “if you’re not there, how do I know if I understood?” (interview 2, 316-
317). In both of her interviews, Beth mentioned listening to the interpreter and patient’s
conversations as a way to increase her listening abilities (interview 1, 310-313). She, too,
emphasized the importance of having the interpreter present to verify her understanding:
“I always listen to what the patient says and try to figure it out before the interpreter tells me, but I…am not able to do that if I don’t have an interpreter there” (interview 2, 45-48). In their use of interpreters, the participants demonstrated metacognitive strategies such as directed attention, self-monitoring and self-evaluation (Chamot and O’Malley, 1994).

Bernice’s use of the interpreter to check her understanding of patient statements has already been discussed, but she was not the only one who checked with the interpreter to verify understanding. Nancy learned how to ask where the baby was kicking by using directed attention while listening to the researcher interpret her question:

Researcher: ¿Dónde le da patadas el bebé?
Patient indicates upper left abdomen.
Nancy: ¿Batadas?
Researcher: Patadas (emphasizing the “p”). “Patadas” are kicks. “Da patadas” is “to kick” (week 2, 55-60)

Nancy also reported hearing the patients say “something like ‘bah-he’” when she had told them they lost [bajaste] weight and asked “does that mean ‘you lost’ too?” (week 4, 300-301). The researcher suggested that the patients might be repeating, “I lost” [bajé] after Nancy reported “you lost” [bajaste]. Similarly, another nurse was able to repeat a patient’s words, but needed the interpreter to explain their meaning:

Patient described ligament pain, but said “pero se quita”
Nurse: “se quita.” What’s that? She keeps saying “se quita.”
Researcher: “It goes away” (week 7, 249-251).

Perhaps the most important factor in the participants’ ability to understand spoken Spanish was the fact that the interpreter was often repeating the participant’s own words in Spanish, rendering the content familiar. As Nancy noted, the interpreter “is saying
what you just said” (interview 1, 427). Kim used this to her advantage, listening to the Spanish so that she could eventually produce it herself (interview 2, 78-83). The repetitive nature of her professional conversations also helped: “I say the same thing to help with the nausea and vomiting so I’m hearing it over and over again. So I’m picking it up now to where I can almost say it myself, without them interpreting” (interview 2, 137-141). Kim further refined her strategy with the researcher by breaking down what she said in English into smaller parts so that she could learn to produce even more, reasoning that the researcher was not already intimately familiar with the content like the paid interpreters were (interview 2, 807-808). Beth also used the interpreter and patient interactions to hone her listening skills. She listened to everything with an awareness that the interpreter was repeating her own words in Spanish. Then she would listen to the patient’s reply, try to figure it out, and then check against the interpreter’s rendition of what the patient had said (interview 1, 306-311).

Gretchen made another important observation about the disparity between listening and speaking. She noted that she could often understand the patient’s reply to an interpreter’s question, but she probably could not have produced the words that elicited the understood response (interview 1, 967-973).

In sum, all the participants in this study functioned at what would be considered a novice-high oral proficiency level in Spanish. They used memorized fixed expressions and understood only one- or two-word responses. None of the participants were capable of survival needs or meeting social demands, the criteria for intermediate oral proficiency ratings. However, the Spanish they were able to control was enough to satisfy limited
work demands and, in some cases, most work requirements. The unique situation of these health care professionals meant they did not fit neatly within existing proficiency criteria.

4.5. Research question 3: In learning Spanish on the job, what are the processes through which the acquisition of linguistic structures takes place?

The participants in this study deployed various learner strategies (Chamot and O’Malley, 1994) to acquire the linguistic structures discussed in section 4.4. These included pursuing specific terms—by asking an interpreter, looking them up, or repeating a key word that was understood—attempting to create with the language, hypothesis-testing, making use of background knowledge, rephrasing, and writing things down. While some participants relied more heavily on one strategy over another, they all used them in various combinations. As Gretchen stated in reference to communicating with Spanish-speaking patients, “you have to apply all these techniques and ways of communicating” (interview 1, 396-397). The interview data discussed below demonstrates the participants’ metacognitive strategies as they talked about various ways in which they had been able to acquire Spanish on the job. Each of the above-mentioned strategies is discussed in detail.

4.5.1 Pursue specific terms

Identifying terms in English that one would want to say in Spanish and seeking those terms is what Ellis (1994) would characterize as a production strategy. Throughout the period of the study, Nancy found this to be an effective method. In her second interview, she reported “I’ve found it really helpful to just get some stuff from you and try to learn it a little bit, try to use it some, and then to be able to go back to you
and…work on it a little bit more--get new input” (113-116). Nancy’s use of this approach to develop a “script” (week 3, 106-124, 228-234; week 4, 446-474, 578-598; week 5, 606-685, 970-978) was documented in section 4.4.1. Throughout the study, she also solicited isolated words such as “gained,” “lost,” “since” (week 3, 120-124), “ready” (week 4, 325), “about” (week 4, 1157-1164), and “every” (interview 2, 239-255; week 5, 566-577). Beth, Gretchen, and Kim all mentioned asking interpreters as a method of acquiring new vocabulary. Beth described this approach: “if I want to try something new, usually…I’ll ask the interpreter, ‘how do you say this?’ Then I’ll try it out on a couple people…and then when I get comfortable with it, then I’ll start incorporating it into my repertoire of Spanish I’m comfortable using” (interview 1, 270-289). Gretchen said she would ask an interpreter, “how would I say this?” (interview 1, 253-254) and Kim said “I’ve been asking, ‘how do you say this?’…‘what did you call that?’” (interview 2, 118-122).

The researcher’s observations confirmed many examples of staff soliciting specific vocabulary. A question on the patient work-up interview form had been changed from dizziness to visual disturbances. Beth said she asked an interpreter how to say “visual disturbances” (interview 1, 263-264). Gretchen said she had continued to use “mareos” [dizziness] and twice asked the researcher to provide her with the Spanish for “blurred vision” [vista borrosa] (week 2, 916-920; interview 2, 202-204). Walking down the hall in front of a patient, Bernice said “ven conmigo,” then looked at the researcher and asked, “what’s another way to say ‘follow me’?” The researcher supplied, “sígame” as an alternative (week 2, 20-26). In interactions with Kim she asked the researcher how
to say “scoop” [porción] (week 4, 273-276), “adult,” “frozen,” and “supermarket” (week 5, 285-297). One nurse who was working on verbs asked the researcher for “did you have?,” “have you had?,” “I will,” and “do you know?” (week 4, 634-678, 1563-1572).

In the process of developing the postpartum script (Appendix I) for the nurses to use, they would ask for additional entries, such as “are you suffering from depression?,” “have you had unprotected intercourse?” (week 5, 866-871; week 6, 364-365). Bernice sometimes sought terms to use for social-psychological purposes, such as “homesick” (week 5, 335-337) and “wood” (week 5, 1018).

There were also cases of the staff asking patients how to say words in Spanish. In one instance, a patient provided Bernice with the Spanish words for “tongue” [lengua] and “under” [abajo] (week 2, 623-6280). She also reported that a patient had told her the word for heartburn [agruras] (week 6, 497). Another nurse had patients write Spanish expressions for her to use, for example “wait here” [quédate aquí] (week 4, 678-695).

Another approach to pursuing specific terms was using written resources to look them up. There were two primary resources that the clinic staff used—clinic fact sheets designed for distribution to patients and reference books. In her first interview, Bernice said she used the Spanish version of a prenatal booklet called “you’re having a baby:” “I would refer to that when I didn’t know how to say something—I’d try to find it” (608-609). When asked if she used the Spanish fact sheets, Beth replied, “yeah, I use that a lot…especially when I first came here to ask about those initial things—swelling and the headache and the dizziness, nausea, vomiting” (interview 1, 254-256). Kim described a notebook full of information in English that had identical corresponding information in
the back in Spanish. She cited it as an easy reference because even the page numbers in the Spanish section corresponded with the same page numbers in the English section (interview 2, 275-286).

The reference books that the participants used included general reference materials, like dictionaries, as well as specific materials. Gretchen said her Spanish-English dictionary “has come in handy for that occasional…[time when]..the interpreter’s off interpreting for somebody else on the staff and the patient and I need to know what x, y, z is” (interview 2, 751-754). Both Bernice and Beth used Spanish books written for English-speaking health care professionals. Bernice said, “I’ve learned a lot of my medical words from that” (interview 1, 722) and Beth said she copied important information out such a book onto to an index card that she used a lot when she first started her current job (interview 1, 429-430; interview 2, 481-482).

Sometimes rather than starting with English and pursuing the Spanish equivalent, the staff would understand a Spanish word and ask an interpreter for the English equivalent. Bernice often heard Spanish-speakers say, “para acá,” [over here] so she asked an interpreter what it meant (interview 1, 424-428). In her first interview, she told the researcher that she heard “le me dicieron” a lot, which would roughly translate to the English, “they telled him me,” but from what she understood, she was able to produce, “le dicieron” [they telled you] (432-442), which a native Spanish-speaker would probably recognize. When the researcher was acting as interpreter for a nurse and a Spanish-speaking patient she was interviewing, the researcher said, “es important consumir suficiente calcio” [it’s important to consume enough calcium], the nurse said, “¿consumir
“suficiente calcuim? That’s easy.” When the same patient described a pain and added “pero se quita” [but it goes away], the nurse asked, “‘se quita’—what’s that? She keeps saying ‘se quita’” (week 7, 231-251). Nancy often understood a single word well enough to repeat it and ask what it meant, as in the following interactions:

Researcher: ¿Dónde le da patadas el bebé?  
Patient indicated upper left.  
Nancy: ¿batadas?  
Researcher: Patadas (emphasizing the “p”) Patadas are kicks. Da patadas is to kick (week 2, 55-59)  
Nancy: I’m hearing something like “ba-he.” Does that mean “you lost,” too?  
Me: “Bajé.” “Bajé” means “I lost” so if you say “bajaste--” “you lost--” they’re probably repeating back “I lost.” (week 4, 300-303)  
Researcher: …pero nada de contracciones seguidas?  
Nancy: What’s “seguidas?”  
Researcher: Continuing, in a row… (week 4, 420-423)

Though the pursuit of specific terms was important to build a vocabulary base that would facilitate communication (Bearden, 1998; Shresta, 1998), it was noteworthy that the vocabulary base was acquired without the benefit of formal instruction. The participants used written resources combined with consultations with interpreters to develop their vocabulary base.

4.5.2 Creating with the language

The participants’ attempts to create with the Spanish language represented what Ellis (1994) would characterize as a learning strategy because through creating they developed linguistic and sociolinguistic competence. The attempts at creating with Spanish will be examined in only two participants, Nancy and Bernice, because they are the two participants who the researcher had the greatest opportunity to observe. Nancy’s
preparation of a script in consultation with the researcher and Bernice’s frequent invitations to have the researcher observe and serve as communicative insurance provided rich data on their creative abilities.

At the start of the study, Nancy characterized her creative abilities as stringing words together, mixing Spanish and English (interview 1, 694-703). In her first interview and early observations she offered examples of her creative repertoire, such as, “menos cinco libras since última cita” (697) [five pounds less since last visit], “¿vomitos cinco times en un día para última cuatro semanas?” [vomiting five times a day last four weeks?], “¿última dos semanas, tiene problemas con nauseas, vomitos?” (714-717) [last two weeks, problems with nausea, vomiting?] (1043-1044), or “¿dónde pies mueve?” [where feet move?] (week 2, 62). During the course of the study, Nancy actively added to her linguistic knowledge while also improving her ability to create with the language by using it. By the time of her second interview, she said she was able to “take bits and pieces of vocabulary or the verbs and actually try to formulate sentences” (148-149). She added that when she tried to do a little creating, it helped her “to have the motivation to try to think, ‘wait a minute, I gotta figure out how to really say that’” (220-221). When Nancy approached the researcher for help in developing her script, she often began by creating as much as she could with the language, as when she followed her own question, “how do I say, ‘I think the baby’s head is here?’,” with the Spanish “creo que la cabeza del bebé….,” (week 5, 673-674). This example was significant because two weeks earlier the researcher had explained Spanish possessives, correcting Nancy’s “cuentas el baby movimientos?” to, “¿cuentas los movimientos del bebé?” (week 3, 229-233) and now
Nancy was demonstrating that she had learned how to express possession in Spanish. Other examples of Nancy’s improved ability to create with Spanish were discussed in terms of her developing script in section 4.4.1.

Nancy’s improved ability to create with the language lent credence Swain’s proposed model of comprehensible output that complements comprehensible input. VanPatten (1998) suggested that comprehensible output might cause language acquisition. Nancy’s comprehensible output seemed to allow her to consciously reflect on her language in use and consequently notice gaps in her knowledge (Shehadeh, 1999) as she tested her own linguistic hypotheses (Grove, 1999).

The influence of comprehensible output was even more noticeable with Bernice, who consistently forged on with creating in Spanish, using what she knew and sometimes making things up that she did not know. With the researcher present as insurance, Bernice once said, “Yo descubrí…is that right? ‘Yo descubrí?’, ‘I discovered?’…I made that up!” (week 5, 1002-1005). After confirming that she had created correctly, she continued “yo descubrí es un milagro para entendimiento*” [I discovered it is a miracle for constipation] (holding up a box of bran cereal) (1005-1006). Though the patient initially understood “entendimiento” as “understanding” [entendimiento] instead of “constipation” [estreñimiento], the communicative interaction was quickly completed. The next week, Bernice correctly created the cognate “oficial” for “official” when she told the patient she would fax a form “para laboratorio reportes oficial” (week 6, 466-468). The researcher suggested that “reportes” might not be an accurate lexical creation and Bernice immediately substituted the correct, “resultados,” and asked if that was better.
Bernice credited using Spanish for social-psychological purposes with improving her comprehensible output: “part of why I like to chit chat with people [is]…I can…learn things because you have to know more than just the medical words, you have to put sentences together” (interview 2, 594-597). Later she added that while her extra chit-chatting did not increase the duration of a patient’s visit because they had to wait for available exam rooms anyway, it did help her learn more (interview 2, 1132-1134). As she suggested, her social-psychological uses of the language tested the outer limits of her creative capabilities, while her knowledge of medical Spanish provided a solid base. She had clearly refined a lot of her Spanish for professional use as the following lengthy examples of dialogue with only minor errors illustrate:

¿Sabe dónde está el hospital? [do you know where the hospital is?] (week 2, 87)

Bernice: En un momento voy a chekar* [chequear] su temperatura. Puede tomar Robitussin DM. ¿Sabe que es? [In a moment, I’m going to check your temperature. You can take Robitussin DM. Do you know what it is?]

Patient: No
Bernice: Te doy un papel [I’ll give you a paper.] (week 2, 603-605)

(Bernice gives patient paper explaining fetal movement count.)
Bernice: No es necesario escribir y regresar; solo es necesario contar los movimientos. Si no es* [está] moviendo 8 movimientos en una hora, llama aquí o el hospitale. ¿Ud. está interesado en información para planificación de la familia? [It is not necessary to write and return; it is only necessary to count the movements. If it’s not moving 8 movements in an hour, call here or the hospital. Are you interested in information on family planning?]

Patient: Sí.
Bernice (ripping off sheet): Información general. Hay una inyección. Si Ud. quiere más información sobre un método, dégalos. [General information. There’s a shot. If you want more information about a method, tell us.]
Bernice (points to the bathroom): Está ocupada. Siempre está ocupada. [It’s occupied.]
Bernice left and came back with a thermometer.
Bernice: ¿Tuviste un cesario con su niña? [You had a Caesarian section with your daughter?]
Patient: Sí.
Bernice: ¿Pero el doctor habló* [dijo] que es posible no cesario? [But the doctor talked it is possible not to have a Caesarian?]
Patient: Sí. (week 2, 609-622)

Bernice: ¿Recibiste medicina para la orina? [Did you receive medicine for you urine?]
Patient: Sí.
Bernice: Tomas dos veces al día. [Do you take it twice a day?]
Patient: Una en la mañana, una en la noche.
Bernice: Ud. tiene…el doctor te dio una receta para una crema? [Do you have...did the doctor give you a prescription for a cream?]
Patient: Sí.
.
.
.
Bernice: Empieza nueve meses. Ud. va a tener examen pélvico hoy para culturas. ¿Ud. firma el papel para la operación? [Nine months are beginning. You are going to have a pelvic exam for cultures today. Did you sign a paper for the operation?]
Patient: Sí.
Bernice: ¿Todavía quiere la operación? [Do you still want the operation.]
Patient: Sí.
Bernice: ¿Tiene su copia del papel? [Do you have your copy of the paper?]
Patient: Sí.
Bernice: Lleva el papel al hospital con Usted y da el papel al doctor o doctora. [Take the paper to the hospital with you and give the paper to the doctor.] (week 6, 63-84).

4.5.3 Hypothesis-testing

Because Bernice invited the researcher to observe and help while she tested the limits of her knowledge, she also provided the majority of examples of use of hypothesis testing to acquire linguistic knowledge. When the researcher and a patient were talking about a crying baby and the researcher said, “nunca se sabe que es lo que quieren” [you never know what they want], Bernice tested her hypothesis: “Oh! I understood! ‘You don’t know what they want’?” (week 3, 413-415). Later she asked the researcher, “it hurts down there when baby moves?” after a patient complained, “siento que me pega aquí abajo cuando se mueve (indicating where with hand)” (week 3, 501-503). Another
patient with a similar complaint put her hand on her lower abdomen and said “el lunes me dolía aquí” and Bernice asked, “on Monday, she had lower abdominal pain?” (week 4, 785-788). Other examples of health care professionals listening to interpreters talk with patients in Spanish and then checking that they understood appeared in both sections 4.3.3.1 and 4.4.2.

Gretchen described the common practice of hypothesis testing in the clinic when she said she would check that she understood a conversation between the interpreter and a patient by asking “you were telling her, she was telling you so and so” (interview 1, 942-944). Ellis (1994) characterized hypothesis-testing as a communication strategy and Oxford (2001) examined hypothesis-testing in terms of cognitive strategies. Rost (2001) mentioned hypothesis testing as important listening strategy, though in this case the hypotheses are tested by asking the interpreter, not the patients.

4.5.4 Background knowledge

Background knowledge is another one of Ellis’ communication strategies and Oxford’s cognitive strategies. Background knowledge is considered important in improving listening skills (Chamot, 1995; Chamot and O’Malley, 1994). When used with listening, activation of real world knowledge is considered a level of discourse processing by Richards (1985). The participants in this study deployed background knowledge in two ways. They drew on their previous experiences with the Spanish language and their previous experience with the patients and their medical conditions.

Gretchen said her ability to pronounce Spanish was developed in high school (interview 1, 772-776) and still remembered the words her father taught her as a child:
“leche,” “pan,” and “cuidado” (interview 1, 800-801). Nancy shared a similar experience of remembering the expression “ojalá que se mejore pronto” [hopefully you’ll get better soon] from eighth or ninth grade Spanish (interview 2, 312-315). Beth said that any ability she had to conjugate verbs was a remnant of her high school Spanish (interview 1, 414-415). Bernice had the most recent experience with formal education, having two courses at a local department of parks and recreation. Her skills reflected some of the materials covered in those classes, especially the early materials on basic verbs and familiar expressions (week 4, 937-970).

Perhaps a more relevant use of background knowledge involved the fact that the staff repeatedly saw the same patients and went over the same information. Gretchen pointed out that having “the experience with the patient over a period of time” was an advantage over the kind of unique encounters that might occur in an emergency room (interview 1, 399-403). She also said, “I pick up things because I’ll know the general topic that’s being talked about; I will pick up what the interpreter and patient are saying” (interview 1, 940-942). Bernice mentioned taking advantage of her repeated experiences with patients when she discussed her strategies for telephone conversations. First she would ask the person for her name “so if it’s a name I recognize, I kind of have a frame of reference” (interview 1, 694-695). She might follow the request for a name by asking the person if she was pregnant (interview 2, 815-817). The researcher observed an example of this when Bernice solicited help on a phone call, first offering all the background information she was able to collect: “I think it’s V____ who came to intakes last week, but didn’t have i.d.” (week 7, 266-268).
The fact that there was so much repetition in their need for Spanish allowed the participants to potentially maximize their strategy use. According to the cognitive learning perspective, they could repeatedly apply successful strategies, such as deployment of background knowledge, so that the use of those strategies became automatic. The automaticity freed up space in short-term memory so that learners could focus on understanding incoming language (Chamot and O’Malley, 1994).

4.5.5 Rephrasing

Another of Ellis’ (1994) communication strategies is rephrasing. It is the only strategy discussed here that could be classified as a social strategy described in cognitive learning theory (Chamot, 1995; Chamot and O’Malley, 1994; Mendelsohn, 1998; Oxford, 2001; Oxford and Nyikos, 1989; Rubin, 1994). The researcher did not observe use of global reprise nor lexical pushdowns (Rost, 2001), though Bernice reported using global reprise in her first interview: “I can say ‘muchas palabras para mí’ or ‘no entiendo, por favor’ you know…” (154-155) and Beth mentioned wanting to be able to solicit repetitions because “I don’t even really know how to ask them to say something again” (interview 1, 357-358). Again in her second interview she suggested that an ability to solicit repetitions “probably would help a lot because a lot of time…I think that they think that I know more Spanish than I do and they’ll just go on and I’ll be like ‘whoa, you’ve just blown me out of the water’” (interview 1, 384-386). The researcher provided Beth and other staff with a list of possible global reprises and lexical pushdowns based on Vandergrift’s (1997) suggestions of appropriate expressions to improve reception.
strategies in interactive listening (Appendix K). Beth’s comments emphasized the apparent imbalance in productive and receptive proficiency.

Bernice mentioned using circumlocution: “if I try to speak Spanish and I don’t know the terms, I try to think of other ways to say them” (interview 2, 249-150) and offered the example of saying “planificación de su familia” [family planning] for “birth control” (264-266). She also said she would rephrase what she thought a patient said, especially when there was not an interpreter available (interview 2, 335-338). She illustrated with a story about a couple who came in who she could not understand so she just continued to ask them “is it this?, “is she pregnant?,” “do you need a doctor?” until they answered yes (344-360). On one occasion Bernice was observed rephrasing a patient’s complaint of contractions—“dolor en el vientre—se pone duro” [stomach pain—it gets hard]—to confirm that she had understood it: “So, ¿su problema de hoy es cólicos” [so, your problem today is contractions?] (week 3, 393-397).

As Bernice pointed out, rephrasing, requests for repetition, and circumlocution were most used when there was not an interpreter available, which might explain the paucity of data collected on rephrasing. The researcher’s participation as an interpreter eliminated the need for staff to resort to rephrasing when she was present.

4.5.6 Written information

The production strategy (Ellis, 1994) of writing down new information had as much to do with learner styles as with learner strategies. Both Nancy and Gretchen stressed the important role of seeing things in their written form before they could learn them. Gretchen said, “I’m a really concrete visual person” (interview 2, 143-144). Nancy
said, “it helps me to see things written…I’ve had just enough Spanish [so that] it means something to see…how it’s spelled and see how it’s written” (interview 1, 920-922).

Nancy also referred to the act of writing as a factor in her learning, saying that “writing actually helps me to learn something and…organize my thoughts” (interview 1, 924-925). She remembered that in college she recopied notes because the writing process helped her commit information to memory (interview 2, 428-430). Bernice, on the other hand, felt that she only had to see some words in order to learn them, while others she could learn just by hearing them (interview 2, 609-611).

For some of the staff, the researcher’s presence as a resource meant having someone to provide written information that would serve as a visual reference in oral communication. Nancy said it helped to “have those basic conjugations written…to be able to look at” (interview 1, 1059-1061). One nurse requested verb cards, such the future card that had the following printed on the front:

I will…
Voy a + verb
Ahora voy a chequear, tomar..
(Now I am going to check, take, etc.)

and on the back:

FUTURE
voy vamos
vas + a + verb
va van
You will go = vas a ir, etc.

Gretchen requested similar cards with the verbs “saber” [to know], “recordar” [to remember], “tener” [to have], and “necesitar” [to need] conjugated on one side and their uses and meanings on the other.
Nancy asked the researcher to write the Spanish for “do you have enough vitamins for two to three weeks?” [tiene suficiente vitaminas por dos a tres semanas?] and only understood the Spanish word “suficiente”—exclaiming “oh, it’s ‘sufficient’”—when she saw it in writing, confirming her earlier assertion that she was a visual learner. When the researcher was trying to teach Kim the expression “antes de levantarse” [before you get out of bed], Kim understood and repeated, “antes de,” but after the researcher’s third repetition of “levantarse,” Kim said “you’ll have to write that down” (week 4, 232-241).

Writing was also used as a way to commit fixed expressions to memory, after which the written material would be thrown away. Nancy said that sometimes she went through her written materials and made the assessment, “well, I know that. I don’t need to refer to that one anymore” (interview 2, 162-163). Gretchen shared her experience with learning the phrase, “¿nos ha dado la muestra de orina hoy?” [have you given us a urine specimen today?]: “I simply read it each time and eventually I could throw the paper away and that was it” (interview 2, 21-22). It was with the same intent in mind that Gretchen asked the researcher to write down terms such as “vista borrosa” [blurry vision] and “trabajadora social” [social worker] (interview 1, 528-533).

The researcher’s observations together with the participants’ interviews showed that various, overlapping strategies were used to learn Spanish on the job in the clinics. Those strategies included pursuing specific terms, attempting to create with the language, hypothesis-testing, making use of background knowledge, rephrasing, and referring to or constructing written materials.
4.6 Research question 4: What are the linguistic needs of the English-speaking health care professionals in the perinatal clinics?

Each participant had different gaps in her knowledge of Spanish, which demonstrated the importance of identifying individual needs so that they might be addressed. Kim, Gretchen, and Beth all wanted to expand on their fixed scripts. Kim felt that she needed fixed lexical items and an expanded script (Appendix J) in order to be better understood by her patients (interview 2, 684-686; week 3 494-529). When asked what resources she would need to improve her Spanish, Gretchen suggested “expanding on the script…to cover virtually all the basics” (interview 1, 733-734). She said she wanted fixed lexical items and expressions to facilitate interactions she regularly had with patients (interview 2, 72-75, 197, 500-503). It was from the first interview with Beth that the researcher started creating written scripts for all the staff, beginning with the postpartum script (Appendix I) and adding the expressions for reception strategies in interactive listening (Appendix K) (interview 1, 357-359; interview 2, 151-154; week 4, 354-389, 731-737). Bernice requested help with conjugating verbs in the preterite aspect of the past tense (interview 1, 559-568; 722-724). The researcher provided Bernice with a pocket book of verbs and a three-page grammar explanation (Appendix L). Bernice used pieces of hot pink sticky notes to mark the pages in the verb book with her most commonly used verbs in the preterite: “to see,” “to give,” “to have,” “to do / to make” (interview 3, 93-120). Nancy wanted to “bump up a level in [her] communication abilities” (interview 1, 595). In her first interview, she said she would like to “focus…on a couple of things and then just use that and then maybe get a little bit more…gradually expanding vocabulary…and then maybe gradually learning some…new verbs and new
conjugations” (605-609). Nancy literally had lexical gaps in otherwise complete sentences (interview 2, 211-213, 694-695), needing words such as “since” (interview 1, 695-697; week 3, 51-52), “times” (interview 1, 714), “gain,” and “lose” (week 3, 53).

The general linguistic needs of the health care professionals in this study as observed by the researcher have been divided into seven categories, each of which is discussed in detail in the rest of this section.

4.6.1 Instruction

The need for instructions was manifested in two principle areas: on the job learning and some kind of formal instruction. The participants emphasized that they needed Spanish to use immediately on the job, which had disadvantages as well as advantages. Among the disadvantages was a lack of time to study and practice (Bernice, interview 2, 529-530). Nancy pointed out that she had to fit working on her Spanish into the work day, which meant consciously noting her needs during an exam and then “com[ing] out and focus[ing] on it for a couple minutes” (interview 2, 261-263), something that her schedule did not always allow her to do (interview 3, 168-181). Beth said that learning on the job meant learning new information at the same time as she actually had to use it, suggesting that it might be nice to have time to think about and process new information without “someone sitting there trying to understand what I’m saying” (interview 2, 434-435). Nancy indicated that the opportunity to immediately use what was learned was also an advantage: “we’re…in the unique situation of really being able to use it and be immersed in it so it’s not like we’re just studying a bunch now to take it and go away somewhere…some other time” (interview 1, 864-868).
The researcher’s presence allowed for the advantage of direct instruction in the workplace that would not have been otherwise available. All of the participants mentioned a need for formal instruction to advance their Spanish-language skills. Beth said she felt “like I’m probably not going to get a whole lot better without some kind of…structured education” (interview 2, 364-366). Later she added that she thought a class would allow her to “progress a little bit more and then…probably plateau again and be stuck” (interview 3, 84-87). Gretchen thought she needed to set out a course of study that was tailored to the kinds of interactions she had with patients (interview 2, 736-739). In addition to formal instruction, Bernice wanted to “be in a situation where I have to do it” (interview 1, 671) as would be the case in an abroad experience. Clinic staff who had sought formal instruction stressed the importance of an appropriate level and pace of instruction. Kim started taking a class offered by the Health Department, but stopped going because the material covered was too basic (interview 2, 733-735). A medical student reported having a similar experience with a medical Spanish class that she took while in medical school. She said the pace of the course was too slow, given that most medical students had previous experience with language classes, and the focus on vocabulary was unnecessary because there were plenty of appropriate reference books available with specific medical vocabulary. She wanted an intensive presentation of the grammar with practice in listening (week 2, 765-777). One of the doctors in the clinic was also frustrated at her attempts to pursue formal instruction in Spanish. She said her study of French in college meant “I know how to learn a language,” but her pursuit of
appropriate Spanish courses for a practicing medical doctor landed her in a community program for travelers in which basic pronunciation was still a struggle for some students at the end of the course (week 5, 782-797).

4.6.2 Pronunciation

In both her second and third interviews, Kim mentioned pronunciation as an important element in increasing her vocabulary: “I can list you tons of words that I would love to know…in Spanish, but what’s the correct way of saying it” (interview 2, 319-321; also, interview 3, 309-313). The researcher observed several cases of mispronunciation, some of which interfered with communication. Most of Kim’s pronunciation problems involved cognates, such as “cereal” (week 4, 232) and “vegetales” (week 4, 261) that she pronounced as she would in English. In the case of the word “estas” [these], which she was reading from the script prepared by the researcher (Appendix J), she pronounced it like the Spanish verb “estás” [you are], probably because she was more familiar with the verb. Nancy often said “baby” instead of the Spanish, “bebé” when asking if the baby was moving (week 3, 218; week 4, 579-580), but patients generally understood the word. The nurse who had a patient write the Spanish “wait here,” pronounced “quédate,” as “quita,” [take away], a different word altogether. She had tried to write “quédate” phonetically as “kdate,” but that did not help her when she used it (week 4, 688-693). When Bernice was casually offering advice on bran cereals that would relieve constipation, she pronounced “estreñimiento” in such a way that the patient understood “entendimiento” [understanding] (week 5, 1005-1014).
Some existing medical Spanish texts begin with concise pronunciation guides that would help health care professionals learn the general pronunciation rules in Spanish. In her text, Medical Spanish, Bongiovanni (2000) provides a complete pronunciation and accentuation guide in less than two pages. Harvey (2000) includes a similar guide in Spanish for health care professionals.

4.6.3 Phone skills

Telephone calls were particularly difficult for the participants for a variety of reasons. Talking on the telephone lacked the important paralinguistic aspects of face-to-face conversations. Additionally, when a patient called the clinic, she was in the position of soliciting information from the staff, instead of the other way around as was customary in clinic interactions. As a result, the staff found that they needed more listening skills in a situation in which they had less support from paralinguistic cues and less control over the interaction. In one instance, a patient’s call to the nutritionist resulted in non-communication because the patient hung up before the communicative difficulty could be resolved. She went to the clinic in person, where the situation was resolved and she received the services she sought (week 4, 911-920).

Bernice and Gretchen were able to use background knowledge to get enough basic information from the caller before seeking an interpreter. Bernice said in her second interview that she started phone conversations by asking “what’s your name?” and “are you pregnant?” to activate her own background knowledge (815-817). In one case in which a patient was calling for an interpreter who was not available, Bernice was able to take a message (week 5, 1250-1256). In another instance, she asked the
researcher to take the call, but reported that she thought it was a particular patient who had been unable to have her intake appointment the previous week because she had not had proper identification with her (week 7, 266-268). Similarly, Gretchen asked the researcher to interpret for a phone call that she thought was from a patient who she had sent to the emergency room earlier that morning (week 2, 135-140). The strategy of soliciting basic information before asking the patient to hold for an interpreter allowed for a sustained interaction over the telephone.

4.6.4 Social psychological purposes

In their interviews and clinic interactions with the researcher, both Beth and Nancy expressed a desire to be able to communicate about topics other than pregnancy. They both characterized this as a need for conversational Spanish (Beth, interview 2, 400-401; Nancy, interview 2, 486-488). Beth’s motivation was a desire to provide more thorough care to the patients. She said that with “people who speak English, I end up chatting…more about little sideline things—their kids,…all different social factors affecting their pregnancy—more than I do with the Hispanic patients” (interview 2, 232-237). As a professional, Beth would not deal with issues related to the social factors affecting pregnancy, but she would refer patients to the clinic social worker. On the level of human social interactions, she felt like she did not get to know her Spanish-speaking patients as well as her English-speaking patients. Bernice reiterated the advantages of getting to know patients through social psychological language use when describing the relationship she had developed with a patient who had been seen at the clinic through two pregnancies. She said, “we’re familiar with each other, we know each other…it does
make it easier when you know the person” (interview 2, 14-17). As discussed in section 4.5.2, Bernice employed Spanish for social-psychological purposes as a way to experiment and create with the language in order to expand her knowledge.

When patients brought their older children with them to the clinic, the staff inevitably tried to communicate with the children, but found it difficult to converse about non-medical subjects. For example, one nurse asked a child “¿qué años?” [what years?] because she did not know the Spanish for “how old are you? [¿cuántos años tienes?]”. Bernice told a patient’s son that he was going to be her granddaughter’s boyfriend: “mi nieta va a estar* tu novia” (week 5, 562), but used the wrong verb for “to be.”

Referring to the strategy of chunking visits, Nancy said, “there’s something that feels…good to me about having part of the visit be without interpretation…to feel like we’re really directly interacting” (interview 3, 252-256). As Nancy improved her ability to communicate with patients during the course of the study, she found she wanted to “branch out” and learn to talk about non-medical subjects at work and outside of work. She and the researcher joked that at a party, she could tell Spanish-speakers that they had lost weight and that she hoped they felt better soon (week 5, 525-530). Nancy’s comments showed that social-psychological communication may sometimes be secondary to medical purposes, but both Nancy and Beth’s experiences demonstrated that social-psychological communication might indeed impact a patient’s plan of care.

4.6.5 A sense of grammar

In most cases, the participants in this study either knew the relevant vocabulary they needed or had access to it, but they needed a sense of how the Spanish language
“worked.” As Bernice said, “I have the words…I don’t know how to make a smooth sentence” (week 2, 536-539). Beth wanted to learn “how to put things together to make sense a little bit better, because a lot of times I will know what I want to say [and] some of the words that would be in the sentences that I want to say, but not quite how to hook it all up” (interview 3, 89-92). Nancy echoed Berince and Beth’s sentiments when she said, “I tend to use a lot of paired words to get the message across more than full sentences” (interview 1, 392-393). Nancy added that she preferred not to learn “something verbatim without having some sense of how to put it together because then it makes it harder to use it, to take those…verbs or…word[s]…and know how to put [them] into other sentences” (interview 1, 611-614; also, interview 3, 343-345). As a practitioner, Nancy was less able to rely on a fixed script like the ones the nurses had (interview 1, 617-621). Some specific grammatical concepts that were problematic for the participants included register, pronouns, pro-drop languages, and verb conjugations.

Bernice expressed concern that she might offend patients by mixing the formal [Usted] and informal [tú] registers (interview 2, 826-827). Bernice occasionally mixed registers, as when she asked a patient informally if she had received medicine [¿recibiste medicina?], if she was taking it twice a day [¿tomas dos veces al día?], and then tried to switch to formal, asking, “¿Ud. tiene…?” [do you have…?], but could only produce the informal indirect object pronoun, “te:” “¿el doctor te dio una receta para una crema?” [did the doctor give you a prescription for a cream?] (week 6, 63-68). In another case, Bernice corrected herself, starting to ask in the informal register, then switching to the formal: “¿estás, no Ud. está interesado en información para planificación de la familia?”
[are you, no, are you interested in information on family planning?] (week 2, 612). An informal possessive pronoun, “tu,” caused Nancy to mix registers when she created the question, “¿Usted sabe cuando fue tu última regla?” [Do you now when your last period was?] (week 5, 631-638).

Bernice struggled with the use of direct and indirect object pronouns. In her first interview she correctly articulated the difference between “they told you” [te dijeron] and “they told me” [me dijeron], but said she was confused “when the ‘le’ and the ‘la’ or the ‘lo’ are in front of the word” (interview 2, 6161-625). In the third interview, Bernice reported that she had been practicing the pronouns and had an opportunity to demonstrate when a masculine direct object pronoun [lo] was used to replace the feminine word for “box” [la caja] in the sentence “lo venden por un dólar” [they sell it for a dollar]. She asked, “so isn’t it ‘la’?,” demonstrating her understanding of the use of gendered, third-person direct object pronouns (121-151). Throughout the study, Nancy pursued an understanding of reflexive pronouns, as in the recurring example of a baby’s movements. She discussed it with the researcher in both interviews (interview 1, 1080-1083, 1158-1165; interview 2, 288-293) and in the clinics (week 3, 208-213).

Some of the clinic staff were confused by the fact that Spanish is a pro-drop language that does not require explicit statement of the subject to form a complete sentence, though a simple explanation clarified matters. In her first interview, Nancy talked about “¿tiene contracciones?” [are you having contractions?] and other expressions with “tener” [to have] seeming to be incomplete sentences (998-1004). By the time of her second interview, she had a sense that the subject did not have to be
explicitly stated. Another nurse expressed surprise that “¿tuviste?” was the Spanish equivalent of all three English words, “did you have?” She quickly understood that explicit statement of the subject was not necessary when the researcher illustrated that a Spanish verb, when conjugated, clarified the subject, unlike English (week 4, 640-657).

Verbs posed the biggest obstacle to comprehending Spanish grammar, perhaps because they are not fixed lexical items and they have to be conjugated in various tenses to enable communication. For example, Beth said she knew a lot of verbs as vocabulary items, but did not know how to conjugate them “to make sense” (interview 2, 405-408). Likewise, Gretchen said verbs were “what always get me really hung up” (interview 1, 267-268) and spoke for her colleagues as well when she said “I think that’s where we feel our weakness is” (interview 2, 730). In her first interview, Bernice said it would be nice to have a verb resource that showed her how to say “did they tell you?,” “did you take your medicine?,” “did you….?” She explained that she might use a verb, conjugating it in the wrong tense, but still communicate the meaning, adding “but it would be nice to do it right” (723-727). In her second interview, she provided the example of communicating “did you sleep last night?” by conjugating the verb in the present and then adding “last night” [duerme anoche?] while gesturing with her head to indicate past. Kim reported doing “everything in the present tense because I figure maybe they’ll at least understand kind of,” but she acknowledged that “if you say, ‘I’m going to go do it to you’ or ‘did you go do it?’ there’s a big different in communication versus what I say [‘go’]” (interview 3, 246-255). Nancy also said she would like to learn to conjugate verbs, adding that she needed to review verb tenses in general: “when you get into talking about
all the different tenses and conjugations, I don’t remember what they are even” (interview 1, 1108-1110). Nancy and the researcher discussed that in Spanish present tense can be the equivalent of the English present or present progressive so the Spanish “¿tiene?” could mean “are you having?” or “do you have?” (interview 1, 998-1012). The subject came up again in the clinic, both with the verb “tener” [to have] and the verb “tomar” [to take]. The researcher explained that both “¿tomas?” and “estás tomando?” mean “are you taking?” (week 3, 109-120).

Nancy (interview 1, 1040-1045), Bernice (interview 2, 898-918), and another nurse (week 4, 634-678) in the clinic all requested information on how to use the present perfect and future in Spanish. The researcher explained the compound future to Nancy (week 5, 649-653) and the other nurse (week 4, 662-665) so that they could use it with any verb. Bernice had learned the same information in the class she took at a local Department of Parks and Recreation, but did not know that it was the more common way of expressing future in speech (interview 2, 731-738). For Nancy and the other nurse, the researcher provided present perfect as a fixed expression, writing “have you had?” and it’s Spanish equivalent, “ha tenido?” on a card. Bernice said she already knew that information, but did not know how to form the present perfect in general. The researcher quickly explained it and then at Bernice’s request provided infinitives for her to conjugate in the present perfect (interview 2, 898-918).

Most of the clinic staff was satisfied with trying to use the present perfect to get information from the patients about the past. Bernice, however, often tried to use the preterite aspect of the past tense, though she struggled with it, as the above example of
her attempt to ask, “did you sleep last night?” illustrated. She thought she heard patients and interpreters saying “dieron” for the English, “they said.” The researcher explained that that would be a regular conjugation of an irregular verb, roughly the equivalent of saying “we goed” instead of “we went” in English (interview 1, 579-582). She had learned “fue” and “fui” and said it was convenient that they meant both “to go” and “to be” in the past (interview 1, 735-748). She was able to conjugate some regular verbs in the preterite, such as when she asked a patient if she received [recibiste] (week 6, 63) and when she said that she had discovered [descubrí] something (week 5, 1002).

4.6.6 Written resources

The participants needed Spanish-language materials to distribute to the Spanish-speaking patients as well as written reference materials to refer to themselves. As important as having reference materials in Spanish was getting the necessary information into a form that was useful for each individual user. Computers were not deemed a practical resource because the participants did not have access to them during the work day and did not anticipate getting computers in the work-up and exam rooms in the clinics (Beth, interview 2, 316, 337-342; Nancy, interview 2, 125-129).

Spanish-language materials had been provided for distribution to patients by the time of data collection for this study. Gretchen said that the fact sheets were being prepared in Spanish when she started working in the clinics three years earlier. She emphasized the importance of having all written materials for distribution to patients prepared for readers with a fourth-grade education, regardless of language background (interview 1, 703-704). As discussed above in section 4.3.2, some fact sheets, like the
bulleted list of four medicines that are safe to take during pregnancy, would be appropriate for someone with limited reading skills, while others, like the letter to patients about the hospital tour, contained a lot of unnecessary formal language and unclear presentations of essential information.

All of the participants mentioned published reference materials as resources, though few actively used the resources they had. Bernice said “I have verb books at home and I lost my motivation to study” (interview 2, 653). Bernice also had class materials from the courses she took at the local Department of Parks and Recreation (week 4, 946-1011). Beth had Harvey’s (2000) Spanish for health care professionals and two other reference books, but no longer used them (interview 1, 292-295; interview 2, 480-482). Gretchen said “I keep buying books and they sit there and occasionally I open one up” (interview 1, 218-219). Nancy mentioned resources that contain phrases, verbs, and vocabulary, but added that they were only useful if one was in the conscious habit of using them (interview 1, 886-889).

The fact that so many written resources went unused by the participants in this study highlighted the importance of having the information they needed in a form that they could use without interrupting their work. Beth stressed that it would not be practical to interrupt a patient interview to find a book and look up a word or expression (interview 1, 298-299, 400-406). Reference books were cumbersome to carry around and the participants in this study worked out of three different clinics with multiple work-up and exam rooms in each clinic.
Once linguistic needs had been determined, it was not difficult to get them in a form that participants could use. When she started her job, Beth used the reference books she had to prepare an index card with all the initial interview questions—information that she had since learned by heart (interview 2, 481-482). Nancy used Health Department letterhead to prepare similar portable references specific to her needs. She also requested and was provided with a pocket-sized verb reference that she would be able to carry in her lab coat (interview 2, 175-179).

In the course of the study, the researcher worked with the participants to create portable references containing only materials they needed, such as the postpartum sheet (Appendix I), the nutrition information sheet (Appendix J), and the expressions for reception strategies in interactive listening (Appendix K). When Bernice saw the nutrition information sheet for the first time, she said, “that’s what we really need!” (week 6, 317) and commented that Beth had been able to conduct a postpartum interview the day before without an interpreter because she had the postpartum sheet (week 6, 318-319). Beth reported that the postpartum script she had taped to the table in her work-up room “helps a lot” (interview 3, 45). When Kim was asked if the nutrition script had been helping, she answered “I use it all the time, I must say” (interview 3, 17). Identifying specific needs and then preparing written scripts was the most useful approach to language acquisition for this group of participants.

4.6.7 Listening needs

Perhaps the most problematic need of the participants involved their receptive abilities. The participants were all able to speak to the patients better than they could
understand the patients, creating a communicative imbalance. The participants were metacognitively aware of this imbalance. When the researcher and patient were discussing the advantages of having a baby in the summer, Bernice joined in, “see—mi problema, no entiendo mucho. Did you say it’s better to be pregnant in winter?” (week 5, 1190-1191). Gretchen acknowledge that “ninety percent of what the patient is saying in Spanish, I don’t understand” (interview 2, 259-260). In her first interview, Beth said “I don’t need…to talk a whole bunch. I need to be able to understand what I get back from the patients” (438-440), adding that “it doesn’t do much good to…know how to ask a question if you can’t understand what they say back” (445-447). Kim said, “I’m not used to hearing it be spoken so I’m…more learning how to listen” (interview 2, 53-54). Later she concluded that “…it’s all about the listening” (676). Nancy said she often neglected listening: “I so often tend to think about the information that we have to give out that…you can forget about the whole aspect of needing to be able to hear and understand more, too” (interview 1, 597-599).

When discussing how much she had learned in the course of the study, Nancy said “I’ve learned a little bit more in the speaking than the listening realm. And I’ve found that sometimes if…I’ve gotten pretty good with several lines, then…somebody will give me this real long, involved answer” (interview 2 40-44), thinking she knows more than she does (interview 1, 174-176). Nancy also suggested that sometimes so much concentration was focused on asking questions in Spanish that she forgot the importance of trying to understand the responses of her patients (interview 3, 141-146). In her third interview, Kim reported an improved ability to communicate with Spanish-
speaking patients with the nutrition script (Appendix J), but also said that “it leads them to believe I know a little bit more” (19-20). Later she added that “they think [I] know a lot more so then they talk a little bit more and I don’t understand it” (27-29). As Nancy’s and Kim’s comments demonstrated, the productive aspect of learning was an issue of memorizing “lines” or “scripts” like an actor—an approach that did not work for the receptive aspect of learning and might mislead the interlocutor as to the proficiency of the speaker.

The participants could describe the spoken Spanish that they could and could not understand. All were concerned with accuracy, emphasizing the importance of being able to understand all the details of what a patient said. Bernice said she can understand “little, short phrases” (interview 1, 121-122; also, interview 2, 324) and “yes/no” answers (interview 2, 323), but nothing “too complicated or too deep” (interview 2, 321). Nancy said, “sometimes I get short answers and then I can get them, but it’s more the long, involved answers that are, like ‘wait a minute, that’s outside my realm’” (interview 2, 67-70; also, interview 1, 177-178).

Beth went into more detail on the limits of understanding. She could understand “yes/no” answers (interview 1, 97-98; 328-329) and single-word details about where—“my back” or when—“at night” (interview 1, 111-112, 334-335), but when patients added details like, “right before I go to bed,” she could not understand them (interview 1, 112-113; also, 140-141). Something like this happened to Bernice when she was trying to make an appointment for a patient. She understood “Friday” and “early,” but did not get the details that she was available early in the day on Fridays (week 5, 548-
Bernice also noted that she communicated more easily with the “quiet” patients: “my observation is that the best learning experience for me is with the quiet ones because if they’re talkers like me and they start blabbing…” (week 6, 95-98).

Because the necessary listening skills could not be acquired through provision of fixed scripts to be memorized, the expressions for reception strategies in interactive listening (Appendix K) that the researcher provided might not have been as useful as the scripts prepared for production. However, by using expressions such as “más despacio, por favor” [slower, please], “por favor, ¿puede repetirlo?” [can you please repeat that?], “¿me lo puede explicar de otra manera?” [can you explain it another way?], or “¿me puede dar un ejemplo?” [can you give me an example?], the participants might have been able to elicit the information in a form they could understand, therefore allowing the communicative interaction to continue, as well as communicate that their listening skills were not as strong as their speaking skills (Beth, interview 1, 384-387; Nancy, interview 1, 174-177).

In her third interview, Beth reported success with using “más despacio, por favor” (34) in two respects. First, she said when the Spanish-speaking patients “slow down and repeat it or say it a different way” (36-37), she was able to understand more. Second, by using the expression, she was able to communicate that she was “having a little trouble understanding them” (38), thus conveying the important information that her receptive skills were not as strong as her productive skills in Spanish.

In Kim’s third interview, she said that her improved production skills with the nutrition script (Appendix J) gave her the confidence to try the expressions for reception
strategies in interactive listening (Appendix K). She reported asking Spanish-speaking patients questions such as, “‘what did you say?,’ ‘what was that?,’ ‘what word did you use?’” (42-45).

Through the study Nancy was made more aware of the importance of listening and working on ways to improve that aspect of communication. In her third interview she described an interaction in which she initially did not understand the patient, but was able to use reception strategies in interactive listening:

I asked her to repeat it…more slowly. And pulled out pieces and then she…realized that I was really…trying hard to listen and so she kind of rephrased some of the things to make it a little more simple and more slow and…we got through it (131-135).

The participants also expressed concern over the accuracy of their understanding. They did not want to guess without confirming in some way that they had understood accurately. Bernice said sometimes she guessed and was pretty sure she was right, but added “it’s not fair to the person to not be one-hundred percent sure” (interview 1, 122-124). Bernice usually relied on interpreters to clarify or confirm her understanding (interview 2, 326-328). Beth said she also used interpreters to “make sure I get for sure what [the patients] are saying” (interview 1, 333). Nancy identified the primary need of the participants in this study when she said “I still need to bump up a little bit more and really try to hear a little bit better…understand a little more that’s spoken” (interview 2, 555-557).

Though the participants in this study did have varying individual linguistic needs, their workplace language needs fell into predictable patterns, just as Svendsen and Krebs (1984) asserted. These five participants all expressed or demonstrated a need for a sense
of grammar, especially verb conjugations. They all required on-the-job instruction, even if it were part of a formal course. Written resources, both for their own purposes and for distribution to patients, were important to all participants. Despite it normally being considered language that precedes profession-specific language skills, all participants expressed a need for Spanish for social-psychological purposes. General instruction in the pronunciation system of Spanish would have been useful for the participants. Perhaps the greatest area of need among the participants in this study was in the area of listening, including phone skills.

4.7 Research question 5: What are the cultural needs of the English-speaking health care professionals in the perinatal clinics?

Both Pedersen (1995) and Gimenez (2001) emphasized the need to become aware of one’s own culture and culturally learned assumptions before attempting to understand other cultures. It is through joint exploration of one’s own culture and the culture of one’s interlocutor that an alliance may be formed between a patient and a health care professional. While acknowledging that the nature of the human condition means that some similarities will be shared across cultures, it is also important to understand that beliefs and customs vary by culture, and that health care should be provided accordingly (Pedersen, 1995; Reynolds and Leininger, 1993).

The culture of the clinic setting in which the participants in this study worked differed from the medical setting of private doctors in this country in many respects. For each visit, patients usually spent two or three hours in the clinic. After signing in, patients waited to be called for the initial interview, after which they waited again to be called to an exam room. Once in an exam room most patients had to wait twice: once to
be seen by a practitioner and a second time to follow up with the interpreter, in the case of Spanish-speaking patients, or with the attending doctor, in the case of a medical student doing rounds in the clinic. After the exam, patients had to wait to see the charge nurse who conducted an exit interview with each patient, at the end of which the patient either left or went to see the nutritionist and/or social worker. While the services provided at each stage of the visit were compartmentalized, there was a great deal of overlap. For example, the practitioner might review the information revealed in the initial interview during the exam in order to make a diagnosis and the charge nurse might revisit that same information again in order to follow-up with medication or an outside appointment. The provision of education to clinic patients also contributed to the overlap, as patients often saw different practitioners at different visits. For example, two different practitioners might provide overlapping or contradicting education on birth control, including use, side effects, cost, and other advantages and disadvantages (week 1, 31-44; week 3, 138-140, 256-290; week 4, 1649-1656). When one patient told a practitioner she wanted to use the injection, but another doctor had told her she might have problems with blood pressure, the practitioner consulted the patient’s chart and said that she should not have problems with blood pressure (week 3, 138-140). In another case, a patient said she wanted to use the pill, but the doctor she had seen previously had suggested the interuterine device. The practitioner proceeded to explain the relative convenience, expense, ease of use, and side effects of the two methods and the patient interrupted to say “la otra ya me explicó todo” [the other (doctor) already explained everything to me] (week 4, 1664-1676).
During such long visits, the patients received numerous services that are not normally provided by private doctors. While waiting in the lobby, a childbirth educator talked to individual and small groups of patients about pregnancy, childbirth, and infant care. She might show a video to a large group or sit with one patient and a doll, demonstrating how to breastfeed. The nutritionist offered nutrition counseling to all patients, many of whom qualified for a free food program which she also coordinated. Patients were regularly referred to social workers, who arranged payment plans and other financial aid in addition to carrying out their social advocacy work in the clinics, hospitals, and domestic spheres. Beyond providing basic perinatal medical care, the staff spent time educating patients about every aspect of pregnancy and childbirth, follow-up care, use of medications, and even distributing maps and giving directions to other facilities. By its nature, the operation of the public clinics also included vast amounts of paperwork at all stages of care, with the possible exception of the actual patient exams, where the practitioner made notes in the patients’ charts as in any health care setting.

One of the earliest observations made by the researcher in the clinic setting was the pleasure the staff took in their work. The researcher noted in her journal that the members of the staff she met the first day in the clinics liked their work and seemed to want to be there. This commitment to their work and their patients was illustrated in a discussion that the researcher observed between a social worker and an interpreter who expressed admiration for a clinic doctor, of whom they said, “if you have a problem or become high risk, he won’t quit until you’ve been taken care of” (week 6, 123-124). They said he drew pictures and explained things to patients, arranged for visits to his
private practice, and in one case arranged for elective reconstructive surgery. The researcher left the clinic one morning with the same doctor and a laboring patient, who he was driving to the hospital.

Having now described the culture of the clinic setting in which the participants in this study were observed, the rest of this section will be dedicated to a discussion of cultural issues specifically related to the language and culture of Spanish-speaking patients who were treated by English-speaking health care professionals in the clinics.

4.7.1 Cultural consideration

In discussing differences between their Spanish-speaking and English-speaking patients, most participants said the same basic information was covered with every patient, regardless of language background (Bernice, interview 1, 199-216; Beth, interview 1, 196-198, 564; Gretchen, interview 1, 345-347; Nancy, interview 1, 461-470). Beth made the important point that “basically what women are concerned about doesn’t differ a whole lot. They all want a healthy baby. They all want to know what they can do to help themselves have a healthy baby” (interview 1, 200-203). Bernice said that English-speakers are supposedly more business-like, but she found that it varied on a person-by-person basis (interview 1, 1012-1014). She had concluded that “the more different kind of people I work around, the more similarities I see with people” (interview 1, 981-982).

These observations made by the participants supported Pedersen’s (1995) and Reynolds and Leininger’s (1993) assertion that some similarities will be shared across cultures. However, the participants also acknowledged some areas in which beliefs and
customs varied by culture. The relevant cultural issues that emerged from interviews and observations included breastfeeding, birth control, extended family, level of interactivity with health care professionals, food, attitudes towards poverty, and the role of native-speaking interpreters.

4.7.1.1 Breastfeeding

Beth recalled a “terrible experience” (interview 2, 550) trying to communicate with a Spanish-speaking patient at the hospital where she worked before her current job. It was the only experience with a Spanish-speaking patient in her entire twelve years at the hospital. Beth tried to help the woman breastfeed her baby, but the woman refused and they were unable to communicate about the issue. Eventually a doctor in the hospital was able to provide the missing information: the woman probably would not breastfeed her child until she went home because in their culture they wait for the milk to come in before they will put the baby on the breast (interview 2, 537-543). While helping a childbirth educator who already spoke a lot of Spanish prepare to teach about breastfeeding in Spanish, the researcher reminded the childbirth educator that many Spanish-speaking patients would wait for their milk to come in before attempting to breastfeed. The childbirth educator was not aware of that important cultural difference (week 4, 895-900).

In the United States, it is considered important to begin breastfeeding as soon as possible after birth so that the baby will both learn how to nurse and consume the colostrum that is produced before the breastmilk comes in. A nursing mother in this country is told that her milk will come in as a result of the baby nursing and this
information is widely proliferated to new mothers in the hospital. Clearly another approach has met with success in other cultures, but the “education” provided in good conscience at hospitals in this country may actually discourage Spanish-speaking mothers from trying to breastfeed, especially if they are not able to reconcile their own cultural practices with the information provided in U.S. health care settings. Bernice summarized the situation concisely when she said, “we’re ruining it for them now…we overcomplicate it…if we’d leave people alone and not give them so much darn information and supplemental bottles, they’d be fine…something they would do more naturally, we overcomplicate” (interview 1, 856-863).

Kim, the nutritionist, noted that while the Spanish-speaking patients automatically breastfed in their home countries, here they asked for formula, which she provided through the free food program that she coordinated. She hypothesized that “they believe that’s what they should do” (interview 2, 437). Kim added that a year or two before she would not have asked a Spanish-speaking patient if she were going to bottle-feed, because “they would just breastfeed” (448), but recently many pregnant Spanish-speaking patients had been telling her that they were not even going to try to breastfeed (444-448). Because of this sudden change, Kim had been tempted to ask why they were not going to attempt to breastfeed, but then she realized that she would not have posed such a question to an English-speaking patient who professed a preference for bottle-feeding (460-464).
4.7.1.2 Birth control

In the spirit of understanding one’s own cultural perspective, Gretchen described the general attitude toward birth control within the medical community providing perinatal health in this country. She described the challenge of getting the patients “to at least think about family planning” (interview 1, 1047-1048) for important medical reasons, explaining that getting pregnant within a year of giving birth “just isn’t healthy from a lot of different aspects” (1055-1056). While Gretchen clearly viewed family planning as an important part of every patient’s plan of care, she concluded her comments on the subject with the disclaimer, “but that’s also a slippery slope” (1056).

Nancy defended the frank discussions of birth control that were a regular part of all the patients’ care, saying “when you’re working in the area, you get kind of desensitized to talking to…people about something like that” (interview 1, 492-494). Nancy also made a distinction between patients’ comfort levels with talking about birth control and their attitudes toward using it. She said that she did not observe that people were uncomfortable discussing it, “but they do seem to have some of their own ideas…and…attitudes about it. Like if they know they don’t want to use something, then that gets made pretty clear” (interview 1, 497-500).

Beth and Bernice had a different perspective on the patients’ receptivity to birth control, particularly the Spanish-speaking patients. Beth thought that they were providing an important service to the patients who wanted birth control, but that others felt pressured to accept birth control that they might not otherwise want. She said “sometimes I feel like a lot of the Hispanic women take birth control because they feel
like we want them to, not because they really want it themselves. Others, I think really
do want it and we do give them that. But sometimes just all the talk we do about birth
control, they think it’s one of our expectations that they get a shot of Depo before they
leave. And so they get one to go along” (interview 1, 566-572). Bernice echoed Beth’s
sentiments, saying that she felt that it was inappropriate to “push birth control down
people’s throats,” (interview 1, 792) regardless of cultural ascendancy. She hypothesized
that aggressive encouragement of birth control use might “be more offensive to other
cultures than it is to Americans” (794-795). Bernice offered the following approach to
balancing the promotion of careful family planning with respect for individual beliefs and
attitudes: “you tell them about…what’s there and why it might be beneficial, but then if
they don’t choose it, you have to respect that” (interview 1, 797-799).

The participants also noted practical differences in birth control choices. Nancy,
the only practitioner participating in the study, said that her Mexican patients were more
receptive to the idea of using interuterine devices--the most popular method world-wide--
than their English-speaking counterparts who seemed to favor birth control pills
(interview 1, 503-506). Gretchen confirmed that she scheduled a lot of interuterine
device appointments for Spanish-speaking patients, but she felt that the Depo injection
was the most popular method among that population (interview 1, 1051-1053)—perhaps
a reflection of Beth’s comment that some patients accept the shot to please the staff.

4.7.1.3 Extended family

In the chapter of Ríos and Torres’ book, Medical Spanish: The practical Spanish
program for medical professionals (2001), entitled “cross-cultural communication” they
described the important role of extended family in Hispanic culture. For this reason, patients are often accompanied to medical appointments by other family members, with whom they might be likely to consult during their appointments (p. 237). Some participants noticed the increased presence of family members with Spanish-speaking patients. Beth said that when she started her current job she was “amazed” at “how often women are accompanied by their significant other” (interview 1, 555-556). Kim noticed that Spanish-speaking patients had a closeness with extended family that she only felt for her own immediate family (interview 2, 643-650). Nancy was the only participant who mentioned the role of other family members in a patient’s care. She said Spanish-speaking patients seemed reluctant to make decisions about birth control without first consulting with their male partners (interview 1, 501-503).

4.7.1.4 Level of interactivity with the health care professional

Ríos and Torres (2001) suggested that Spanish-speaking patients in medical settings would tend to ask fewer questions and clarify fewer points than their typical English-speaking counterparts (p. 237). According to Ríos and Torres, it is out of respect that patients agree with healthcare providers so as not to challenge the authority of those providing care nor waste their valuable time (p. 238). This situation might complicate matters when a language barrier exists, since it would be hard to determine if such a complacent patient understood what the health care professional was saying. Nancy mentioned that she had heard that Mexican patients might not ask as many questions and said she thought “that might be true” (interview 1, 526). For all patients in the clinics, such vast amounts of information were provided to them at each visit, both orally and in
writing, that they often did not have a lot left to ask about as they might have in a different medical setting, such as an emergency room.

The formal courtesies and requisite preliminary small talk referred to by Ríos and Torres (2001) who stressed that the brief, concise efficiency valued in U.S. culture “would be considered the result of poor upbringing and the height of rudeness and offensiveness” in Latin American countries (p. 239), varied depending on the interlocutors in the clinics. Bernice tried to chat with every patient before starting a visit while Beth regretted that her Spanish skills did not allow her to do so with Spanish-speaking patients in the same way as she did with her English-speaking patients. Bernice was aware of the cultural difference described by Ríos and Torres, but dismissed it, saying “Americans are supposedly more bossy and business-like and other people are more pleasant, but that’s on a person-by-person [basis]” (interview 1, 1012-1014). Not only did the clinics seem to have their own culture, to which the staff and patients alike had adjusted after so many encounters together, the level of interactivity varied according to who the participants were.

4.7.1.5 Food

The issue of food was the clinic nutritionist’s area. At the time of her second interview Kim had just been to a workshop where she learned about dietary differences in the Mexican population in the U.S. and Mexico. She had been told that decreased physical labor in the U.S. combined with dietary changes such as eating fewer fresh vegetables and consuming more flour products instead of corn products, contributed to a higher obesity rate in Mexicans living in the U.S. compared to their counterparts in
Mexico—five times higher for men and four time higher for women (interview 2, 388-486). As the dietary consultant in the clinic, her role was to advise pregnant women on what to eat and not eat during all the stages of pregnancy, including counseling patients on coping with morning sickness, weight loss and weight gain. According to Ríos and Torres (2001) the approach of listing foods to eat or not eat “would be construed as being harsh and unfeeling in Spanish” (p. 238). They advised using an apologetic attitude when suggesting dietary changes, accompanied by reminders that such changes are for the benefit of the health of the patient and the patient’s family (p. 238). Kim was probably not aware of such cultural differences, though she had clearly attempted to understand cultural differences related to food as evidenced by her attendance at the aforementioned workshop. For practical reasons related to a need to communicate across a language barrier, listing foods was a more desirable approach to communicating with patients in the clinics. In this case, the linguistic need of the health care professionals seemed to be in conflict with the cultural cautions of Ríos and Torres.

Kim was aware of the cultural significance of different eating schedules in the culture of her Spanish-speaking patients. A practitioner referred one patient to Kim after finding that the patient typically drank milk for dinner, sometimes with bread or cereal. The practitioner was concerned that the patient was not eating enough, possibly due to lack of resources to purchase enough food (week 1, 251-260). Kim immediately asked the patient what she typically ate earlier in the day and concluded that the patient had a healthy diet. The practitioner had not realized that the midday meal was the biggest meal for most Spanish-speaking patients. Ríos and Torres (2001) reminded their readers of the
Spanish saying, “hay que desayunar como rey, almorzar como príncipe y cenar como mendigo” [one should have breakfast like a king, lunch like a prince, and dinner like a pauper] (p. 241).

4.7.1.6 Attitudes toward poverty

A cultural difference that came up in some interviews was the relative attitude toward poverty. The vast majority of the patients in the clinics had incomes below the poverty line, but the sense of what things were considered a necessity varied. In her first interview, Beth said:

it seems that American poor people still end up with their Nikes and everything else, their clothes matching…they got the Nike hat and the Nike sneakers and the acrylic nails and it seems weird that you can…be in a poverty situation and still be able to manage to take care of all that extra, cosmetic things. When it seems like the Hispanic population, they make sure they got the clothes on their back and food to eat and a roof over their head, and they don’t seem so concerned about what other people think if…they don’t have totally everything just perfectly so….They might have a Christmas t-shirt on in the middle of the summer, but hey, they’ve got a shirt on their back and their husband’s by their side and they’re happy about it (583-594).

The same issue came up in Kim’s second interview. She found that the unemployment rate was lower with the Spanish-speaking families she counseled and said that they seemed not to be “complainers” (576). Kim and the researcher discussed that the Spanish-speaking patients had few consumer products that English-speaking patients considered necessities, but that it might be a case of short-term sacrifice for long-term gain. Some Spanish-speaking patients were using the money they earned in the U.S. to buy homes or support family back in Mexico (576-601).
4.7.1.7 The role of native and non-native speaking interpreters

Ríos and Torres (2001) indicated that interpreters must simultaneously act as direct translators, cultural brokers, biomedical interpreters, and patient advocates (p. 235). This aggregate of roles highlights the fact that interpreting cannot be a culture-free role. The idea that the native-speaking interpreter might not be the ideal interpreter challenged the researcher’s own assumptions. Ríos and Torres explained the issue in the following manner: “socioeconomic class differences openly exist in many Spanish-speaking countries, and attitudes formed by this system often continue to be manifested in the new country” (p. 236). A patient may feel embarrassed or uncomfortable if an interpreter from a higher class was not respectful or an interpreter from a lower class could have worked for her domestically in their native country.

The researcher was surprised by one patient’s assessment that her work-up interview was “sencilla” [simple/easy] with the researcher acting as interpreter (week 4, 1444). Later in the same patient’s visit, the patient answered the social worker’s query as to whether she had any more questions with the comment that in this visit she had received answers to all her question. She said she did not like to ask questions when the interpreter got mad [se enfada]. The researcher explained her own role as a part-time volunteer interpreter and lightheartedly suggested that she might have a different attitude if she interpreted in the clinics all day, every day (week 4, 1543-1548).

The encounter with this particular patient might have been more a matter of individual personalities than cultural issues related to relative socioeconomic status, but it was important because it helped challenge the researcher’s own assumption that
sameness was better than difference when it came to the native language of interpreters and patients. The researcher had assumed that the paid interpreters working in the clinics—one from Columbia and one from Mexico—would be better interpreters simply because of their native language and cultures. However, it was observed that individuals apply negative stereotypes to people from their own linguistic and cultural background, emphasizing the importance of sensitive bilingual native and non-native speaking interpreters, as suggested by Alptekin (2002).

4.7.2 The culture of linguistic transfer

In a study of the pragmatics of making requests in the workplace using second language, Li (2000) concluded that while learning the linguistic system is important for intercultural language use, understanding the communicative environment and how both parties function within it was also important. In this study the researcher found that in learning the linguistic system of Spanish, the cultural connotations of the lexical items were sometimes overlooked, leading to more serious miscommunications than those caused by the cultural issues discussed in the previous section. In her book, Medical Spanish, Bongiovanni (2000) offered the example of translating the English word “abdomen” to “estómago” [stomach] in Spanish. In both English and Spanish such examples of accurate medical terminology being inappropriate for patients who may not understand them abound. The issue of the level of difficulty of medical terminology will not be examined here. The examples discussed below are not necessarily specific to medical vocabulary, but they illustrate the importance of understanding the cultural meanings inherent in the semantics of the language one uses.
4.7.2.1 Fluid, flujo

In the work-up interview, the nurses in the clinics asked the patients if they had had any vaginal discharge, or “¿flujo vaginal?,” which might literally be translated as “vaginal fluid.” In one visit, a patient who spoke a lot of English asked the researcher how to say “flujo” in English. The researcher answered, “fluid, discharge.” Bernice immediately pointed out that in English, one would not use the word “fluid” in such a context and that “discharge” was the only appropriate word. In the discussion that ensued, it was agreed that in Spanish “flujo” only refers to bodily fluids while in English the word “fluid” is commonly used as a synonym for “beverage” or “drink,” particularly in a medical setting in which patients are advised to “drink a lot of fluids” (week 4, 848-859).

4.7.2.2 Pedialyte, suero

Early in the study, a patient who was suffering from morning sickness reported that one thing she was able to consume was “suero.” The researcher, acting as interpreter, only knew the translation for “suero” that means intravenous fluids. After listing various beverages, the researcher asked if “suero” was like “Gatorade,” the patient confirmed that it was. The researcher then asked if it was like “Pedialyte” and the patient immediately recognized the brand name and confirmed that that was what she was referring to when she said “suero.” In future encounters with Spanish-speaking patients suffering from morning sickness, the researcher was able to immediately interpret the word “suero.” In one case, the fact that the patient was consuming Pedialyte was conveyed to the nurse (week 4, 1361) and in another the patient was aware that the interpreter probably
wouldn’t know what “suero” was so she said “nada más tomo agua simple—no sé cómo se llama aquí” [I just drink “simple water”—I don’t know what it’s called here.] The researcher asked, “¿es como suero?” [Is it like Pedialyte?], the patient confirmed, “sí, es suero” [yes, it is Pedialyte], and the researcher told the nurse that she was only drinking Pedialyte (week 7, 136-139).

4.7.2.3 Food, comida

In attempting to translate the question, “are you eating good foods?,” Nancy produced the Spanish word for food, “comida,” and proposed the question, “¿comes buenas comidas?” One of the clinic interpreters offered the alternative term for food, “alimentos,” and the researcher explained to Nancy that the word “comida” could mean “food,” but it could also mean “meals” so the patient might not know if Nancy were asking if she was eating good foods or good meals. Such ambiguity would not exist if she used the term “alimentos” for “foods” (week 4, 457-466).

4.7.2.4 A week, ocho días

In Nancy’s first interview she talked with the researcher about knowing what to listen for in order to improve listening comprehension. The researcher offered the example of “ocho días” [eight days], which was interpreted as “a week” in the clinic. When patients were asked how long they had been experiencing a symptom, their answers often included “ocho días” and “quince días” [fifteen days]. Nancy commented that “it seems like there’s fourteen days in two weeks, not fifteen days” and the researcher pointed out that from last Saturday to this Saturday was eight days (826-841). More than an issue of how two cultures divide time, it seemed to be an issue of
terminology. Just as the term “fortnight” does not enjoy common usage in English today, the patients in the clinic simply talked about the previous week or two in terms of days. In this case the cultural connotations were less important than the fact that understanding different lexical items might better enable communication.

### 4.7.2.5 Bills, billes

When Spanish-speaking patients wanted to see a social worker to help them arrange for payment of their bills, both the patients and the health care professionals used the term “billes.” In Gretchen’s second interview it became apparent that the staff did not know that “billes” was a borrowed word. The researcher explained that in a Spanish-speaking country a different word for “bills” would be used. It was concluded that “billes” was probably the appropriate term for the bills received in this country, but that in their home countries the patients would probably use different words for the bills they received there (538-553). The word “billes” might be part of an emerging variety of English in which words are adapted across two languages.

### 4.7.2.6 To suffer, sufrir

In her first interview, Bernice told the researcher about a patient who wanted to have a baby boy, not a girl, because “las mujeres sufren más” [women suffer more]. Bernice said, “I understood what she said, but I couldn’t really believe I understood her because it seemed such a sad thing” (809-810). She talked with the patient about the suffering of women who experienced domestic violence and had to work hard all their lives. Bernice also understood the term “sufrir” only in the most extreme sense of the English, “to suffer,” which may have been the sense in which her interlocutor intended.
But the term “sufrir” is widely used in Spanish in the sense of “to suffer the consequences,” which does not always imply great suffering.

4.7.2.7 To deliver, aliviarse

Most of the patients in the clinic used the term “aliviarse” for “to deliver” or “to give birth.” In English, the staff might have said “you are going to deliver your baby at ______ hospital.” Bernice told Spanish-speaking patients “Usted va a nacer su bebé en…” [you are going to be born your baby at ____] (week 2, 86-87). The verb “nacer” means “to be born” and the baby would be the subject of the sentence in this context, not the mother: “su bebé va a nacer en [hospital]” [your baby is going to be born at ____].

Thinking that it might only be an awkward lexical transfer across the two languages, the researcher told Bernice that she might hear the patients use the term “aliviarse” for “to deliver” and wrote the verb on a card for her to use. The researcher later observed Bernice using “aliviarse” instead of “nacer” in the same structure as above: “Usted va a aliviarse su bebé…” [you are going to give birth your baby] (week 5, 1027-1028). In both Spanish and English, the woman is the subject and the verb is “to deliver” or “aliviarse” but “baby” is the direct object only in English syntax. In Spanish, either the woman carries out the action of giving birth [aliviarse] or the baby is born [nacer].

4.7.2.8 Enough, suficiente/bastante

Looking up the English word “enough” in a Spanish-English dictionary, one might find the Spanish word “bastante,” but in American Spanish “bastante” is used to indicate “a lot” or “plenty” while “suficiente” means “enough.” To inquire whether a patient had enough vitamins, the best question in Spanish would have been “¿Tiene
suficiente vitaminas?”  *do you have enough vitamins*?]  instead of the more commonly used “¿Tiene bastante vitaminas?” (week 2, 111; week 4, 1014), which would have been understood as “do you have a lot of vitamins?”

More important than the productive uses of the Spanish equivalent of “enough” were the receptive uses. In the clinic setting, a patient might answer the question “did it hurt?” with the word “bastante” to indicate “a lot.” When asked to describe her vaginal discharge, one patient said “normal, pero bastante” *normal, but a lot*. In those contexts, understanding that the patient meant “a lot” or “more than usual” and not “enough” was an important distinction.

4.7.2.9 To go to the bathroom/*ir al baño*

In the context of a perinatal clinic, English-speaking patients easily understood the euphemism “did you go to the bathroom?” to mean “did you give a urine specimen?” Asking a Spanish-speaking patient, “fue al baño?” *did you go to the bathroom?* did not carry the same implications. Going to the bathroom simply means going into that particular room for any reason—to wash hands, get tissues, or otherwise use the facilities. The Spanish-speaking patients might have understood the question as an inquiry as to whether they had to go to the bathroom. Bernice described the “comedy of errors” that ensued when she used that question in the following way: “I’ll say, ‘¿fue al baño?’ and sometimes we’ll get confused like if they want to go or they don’t want to go or should…go now or do they know where to go?” (interview 2, 835-837). Out of habit, Bernice continued to use “fue al baño” (week 7, 41-42) after she had learned to make the request more specific, as Gretchen had. Gretchen overcame the communication problem
by asking an interpreter how to say “have you given us the urine sample?” in Spanish, which she wrote down and read out loud to patients until she had it memorized (interview 2, 21-22). She had to refine it further, adding “hoy” [today] because some patients answered “yes” in reference to an earlier visit, not realizing that they had to give a urine specimen at each visit (Gretchen, interview 1, 1132-1135).

Now having explored the importance of understanding one’s own cultural perspective in order to better understand other cultural perspectives, some specific cultural differences between the Spanish-speaking and English-speaking patient populations, and the cultural connotations of certain lexical items used in translation, the discussion will turn to reciprocity in communication between English-speaking and Spanish-speaking interlocutors in the clinic setting.

4.8 Research question 6: Is there reciprocity between the English-speaking health care professionals and their Spanish-speaking patients in their attempts to communicate in the clinic setting?

The health care professionals participating in this study emphasized their commitment to finding a way to communicate with non-English-speaking patients. Indeed, they did have resources to enable communication, including their own Spanish-language skills used in combination with patients’ English-language skills, interpreters, and a telephone “language line” operated by AT&T. Through these various means, “the same important information is obtained regardless [of] whether they [speak] English or Spanish” (Beth, interview 2, 231-232).

Bernice reported trying “to think of other ways to say” terms she did not know how to say in Spanish (interview 2, 249-251) or asking yes/no questions, such as “are you
pregnant?,” “do you need a doctor?” until she was able to communicate with patients (interview 2, 342-360). Kim also used circumlocution: “if they don’t understand, I keep trying to re-say it and I’ve learned different ways to say…the same thing” (interview 2, 216-219). When asked if she would edit what she said to a Spanish-speaking patient according to her own abilities, Bernice echoed Beth’s comments, saying, “I wouldn’t skip it. If I couldn’t handle it, I would go get somebody” (interview 1, 212-213). Likewise, Kim reported getting an interpreter to verify understanding so that “they can at least have another opportunity” to clarify (interview 2, 239-240). Nancy pointed out that in situations in which the patient and health care professional did not share any common words, they had the good fortune of being able to use the translation services available through the AT&T language line (interview 1, 729-730). Gretchen, however, problematized this issue by calling attention to the fact that the resources did indeed exist to provide the words in any language to a non-English speaking patient. The complicating factor, she said, was assessing the patient’s receptivity of the words that were presumably provided in her own language (interview 1, 346-355).

Gretchen’s concern not with the language of communication, but with whether a patient was “getting it” in her own language proved to be an important issue. Bernice talked about patients “yes-ing” her—saying “yes” whether or not they understood what she said, sometimes with a flat look that indicated lack of understanding (interview 1,536-542). The health care professionals had to trust their own judgement on whether to pursue some other form of communication, such as an interpreter, or take the patient at her word when she said she understood. Assessing whether the patient was reporting a
false “yes” was not an easy task. Bernice joked that she could not say to a patient, “now repeat it all back to me” (interview 1, 533-534). Kim reported uniform lack of success with repeatedly asking the patient, “do you understand?,” something she often witnessed in an environment in which interpreters were not available. She said that she refused to ask Spanish-speaking patients if they understood on the grounds that she would not ask that question of an English-speaking patient to whom she had just explained something. Kim applied her intuition and sought an interpreter when she suspected the patient did not understand something (interview 2, 223-241).

Gretchen also relied on intuition and patients’ gestures and facial expressions to detect false affirmative answers (interview 1, 380-386). Gretchen found a way around the failed global approach of asking the patient if she understood or asking the patient to repeat back what was said, as described by Bernice and Kim. Gretchen asked the patient specific questions about the essential information, such as “when are you going to go?,” “when is your appointment?,” and “when do you have to register? What time?” (interview 1, 371-372). The Spanish-speaking patients’ affirmative answers could also be related to the cultural issue discussed above. According to Ríos and Torres, agreeing with health care professionals out of respect for their authority is the culturally appropriate response (p. 238). Global questions, therefore, might only elicit further affirmative responses, as Kim reported. Asking patients specific questions to verify understanding did not put them in the position of challenging authority, yet it did ensure that they had understood essential information.
Finding compromises that allowed for communication between the health care professionals and their patients were characterized as “meeting halfway” (Nancy, interview 2, 547-551). Nancy was referring to using her limited Spanish together with a patient’s limited English to enable communication. Nancy felt that using her rudimentary Spanish encouraged patients to leave their reluctance behind and try to use whatever English skills they had (interview 1, 321-336). Gretchen also tried to encourage patients to use English by trying to talk to them in their language. She felt using her fractured Spanish helped build trust, which together with the patient’s English skills established a foundation for communication (interview 2, 563-567).

This willingness of both interlocutors to work together on communication was essential to positive outcomes. The participants talked about negotiating with the patients, adjusting speech according to each other’s level. Bernice said she understood when patients kept their responses short (interview 1, 121-122; interview 2, 321-326)—“the shorter the better” (interview 2, 325-326). Beth said she told new patients that she understood very little Spanish (interview 2, 205-207) and reported that slow, simple speech was the easiest for her to understand (interview 1, 128-141). She also reported that most patients knew she had trouble understanding and therefore kept their explanations simple, covering only the “important things” (interview 2, 72-74). The staff also had to adjust their speech for the patients. Reiterating Gretchen’s concern for patient education levels and receptivity, Bernice said she was “against medical terminology” (interview 1, 227) because patients did not understand it in their native languages. She
reported using terms such as “planificación de su familia” [*family planning*] instead of the more technical “métodos anticonceptivos” [*contraceptive methods*] (interview 1, 266).

The researcher observed the patients and health care professionals adjusting their speech, in both their native and second languages, in order to facilitate communication. While making an appointment for a patient, Bernice was put on hold and used the time to confirm the patient’s address by asking in Spanish “¿vives en…?” [*do you live at…?*]. The patient replied in Spanish that the address had changed again and Bernice only understood the Spanish word for “to change,” but the patient immediately pulled a scrap of paper from her purse that looked like it had been ripped from the corner of a larger sheet with an address written on it in clear, large black printed letters. She handed Bernice the paper and Bernice changed the address in the patient’s chart (week 1, 98-107). In another case, the researcher was acting as interpreter for a patient who had to have her blood drawn exactly an hour after drinking a sweetened beverage. As the patient was drinking the researcher looked at the clock on the wall and stuttered, “a las, a las, a las” [*at, at, at…*]. The patient finished the interpreter’s sentence: “veinte para las tres” [*twenty till three*] and the interpreter was then able to quickly finish the sentence, explaining that in one hour they would do the blood draw.

Often communicative reciprocity in the clinics took the form of a mixture of Spanish and English. The researcher observed a receptionist use as much Spanish as she could to make an appointment before switching to English:

Receptionist: ¿siente de octubre? ¿el lunes en la mañana? ¿está bien?
Patient: ¿A qué horas?
Julia: You tell me.

The patient and receptionist agreed on a day and time, then the patient looked at an interpreter and asked, “¿me sacan la sangre?” [are they going to draw blood?]. The receptionist understood and immediately exclaimed, “when?,” looked in the patient’s chart to see what time she needed her blood drawn and said, “Nine thirty! Come on, let’s go.” She jumped up and walked around the reception area to open the door and walk back to the laboratory area with the patient (week 4, 24-30).

Bernice often moved in and out of Spanish according to interlocutor cues. After asking one patient if she had had her nine-month cultures and whether she had medicine from the hospital in Spanish, Bernice asked, “you were in the hospital for two weeks?” while preparing pills for the patient to take home. She added, “I’ll give you twenty. You won’t still be pregnant in twenty days?” The patient asked, “¿y si sí?” [and if I am], and Bernice did not understand the question. The researcher interpreted and Bernice continued, giving the direct answer in Spanish and adding commentary in English: “te doy más [I’ll give you more]. But you won’t still be pregnant. Dr. ____ will deliver you!” Bernice handed the patient the amber bottle of pills with a childproof lid and said, “hasta que nace* el bebé” [until the baby is born.], the patient asked “¿después no?” [and not after?], and Bernice answered, “en el hospital, el doctor te dice” [in the hospital, the doctor will tell you]. The rapport that Bernice had established with this patient during this pregnancy and one previous one was evident at the end of the exit interview when Bernice asked in English, “you drink lots of water?” and the patient answered, “nada más cerveza” [just beer]. Bernice said, ‘beer!? No.” (week 4, 1083-1111). Not only did the
patient know Bernice’s Spanish was good enough to get the joke in Spanish, she also felt comfortable enough with her to make such a joke.

With another patient who Bernice knew liked to practice her English, Bernice said everything first in English and only followed in Spanish if the patient seemed not to understand English. In the last exchange, Bernice tried to clarify when the patient first felt the baby moving in Spanish, but struggled and the patient was able to reciprocate by supplying the Spanish for Bernice:

Bernice: Your due date is January first (looking at chart). Wow. Día fiesta.
Patient: Maybe tiene el mismo día de nacimiento de su papá. [it will have the same birthday as it’s dad.]
Bernice: What’s that day?
Patient: El primero de enero. [January 1st]
Bernice: Oh. Wow. You had your ultrasound at OSU?
Patient: No.
Patient: Sí, Mount Carmel.
Bernice: Your baby’s moving now?
Patient: Sí.
Bernice: Since when? ¿Desde cuándo?
Patient: el 26 de marzo. [March 26th].
Bernice (looking at chart): That’s your last menstrual period. Pero, ¿desde cuándo está…siente…
Patient: ¿…que se mueve el bebé? […]that the baby’s moving.
Bernice: Yes. (week 2, 649-665)

The importance of reciprocity to the learning process was not lost on patients who were trying to learn English and health care professionals who were trying to learn Spanish. Bernice often provided written materials to such patients in both English and Spanish so they could learn from the fact sheets in the same way she had (week 6, 133-137). One patient responded to Gretchen’s interview questions about nausea and vomiting with slow, clear Spanish, “todo el día” [all day], repeating it after each question
to ensure that Gretchen understood even though she was straying beyond the simple
yes/no answers she could have been using (week 4, 1350-1354). When taking a patient’s
temperature, Bernice did not know the Spanish word for “under” and the patient was
accommodating Bernice’s desire to learn more Spanish:

Bernice: (holding up a thermometer sheathed in disposable plastic) I don’t know how to
say… (sticking out tongue)
Patient: lengua [tongue]
Bernice: No, but… “under”
Patient: abajo
Bernice: Oh, you speak English?
Patient (nodding): Un poco (indicating with thumb and index finger)
Bernice: A lot?
Patient: No. Un poquito.
Bernice: Abajo la lengua, por favor, hasta beep, beep, beep (week 2, 623-32).

Other participants mentioned the importance of finding receptive interlocutors
with whom they felt comfortable increasing language learning. When Beth learned
something new she would try it out on a couple patients, but clarified that she did not use
anything new with every patient until she had practiced on patients that “work with you;
they know a little bit of English…you can kind of just go back and forth and you can pick
up a lot that way” (interview 1, 277-280). Nancy said she tried to couple her learning of
Spanish with patients “who you just know and can tell that they’re working on their
English ongoing and have some motivation” (interview 2, 540-542). Nancy stressed the
importance of encouraging the Spanish-speaking patients in their learning of English.
Without realizing it, she had developed the technique of saying things in English, then
saying them in Spanish. In her first interview she reasoned that she was “letting them
hear it in English and then letting them hear it in Spanish right after it so that…maybe it’s
helping their English as well” (350-358). While she recognized that she had to
consciously work on improving her Spanish, Nancy also wanted to remember that the Spanish-speaking patients are learning English so she had to help them “be willing to try to learn as well” (interview 1, 781-784).

The researcher observed active negotiation between the two groups of language learners. The researcher was present the first time Nancy tried to ask a patient in Spanish if she was counting the fetal movements. When she mispronounced “are you counting?,” she practiced again with the researcher and explained to the patient, “I’m trying to practice my Spanish, ________” (week 3, 220-224). Bernice consistently tried to use English with patients who she knew spoke some English and wanted to practice. After getting help with the Spanish words for “tongue” and “under,” Bernice switched to English with that patient, asking if her flu had gotten better or worse. When the patient looked to the researcher for interpreting, Bernice quickly intervened with, “no? I can say it. La gripe. ¿Está mejor o está peor?” [the flu. Is it better or is it worse?] (week 2, 635-639). The same thing happened when she asked a first-time patient if she wanted to try to hear the baby’s heartbeat (week 5, 1220-1224) and with a patient to whom she was offering the fetal movement count fact sheet (week 6, 439-444).

Bernice felt bad when communication difficulties meant she used Spanish with patients who wanted to practice their English. She said it did not seem fair that she got to practice Spanish and not let them practice English (week 2, 693-697). She also said she did not want to insult patients who understood English, surmising that “they can understand me better when I speak English” (week 5, 1241-1246). With some patients, Bernice felt comfortable negotiating to practice, asking if they minded if she tried to
speak Spanish (week 4, 1044-1045; week 6, 463-465). She suggested to one couple, “Ustedes solo hablan inglés para practicar y yo solo hablo español para practicar” [you only speak English to practice and I’ll only speak Spanish to practice] (week 6, 269-270). The flexibility to negotiate language use required some level of social-psychological language. Bernice said that she experienced less anxiety with patients she had gotten to know because the fact that they had a relationship meant “you can ask them to repeat it or say it slower” (interview 2, 21-24). Her familiarity with one patient going through her second pregnancy at the clinics meant that they could work on language together. Bernice said, “I guess and she said she guesses,” indicating that they worked on language together, using both English and Spanish (interview 2, 14-17).

After using the nutrition script (Appendix J) for a few weeks, Kim felt that she was able to establish rapport with Spanish-speaking patients, which meant more side conversations about learning each other’s language and learning each other’s names and faces (interview 3, 70-89). Beth felt she did not get to know Spanish-speaking patients as individuals as well as English-speaking patients because of her lack of social-psychological language. They could not build reciprocal personal relationships through which social factors affecting an English-speaking patient’s pregnancy were often revealed (interview 2, 231-290).

There were occasions when the participants felt that there was a lack of reciprocity. Bernice stressed that it was seldom, but that some patients did not “have a tolerance for your trying…you can tell someone doesn’t want to fool with you” (interview 2, 62-65). In her second interview she added that such situations were
exacerbated when the patient was upset or worried about something (54-55). Likewise, Nancy said that it was only occasionally that she ran into a patient who demonstrated a “refusal to understand any English or…my attempts at Spanish” (interview 1, 239-241). Beth noted that while most patients understood her basic Spanish, once in awhile a Spanish-speaking patient answered “what?” to every attempt she made to use her otherwise widely-understandable Spanish (interview 1, 370-374).

Sometimes a lack of reciprocity was attributable to providing too much information. Bernice gave the example of medical terminology that was difficult for patients of any language background to understand. She felt that it was inappropriate for health care professionals to talk about a patient without clarifying what was being said to the patient. Bernice tried to prepare some English-speaking patients by explaining some of the Latin terms that might be used in the hospital to describe a patient’s condition (interview 2, 227-234). Likewise, patients sometimes strayed from answering the health care professionals’ questions directly, adding information that made the answer more difficult to understand. Even when the interpreter was present to facilitate communication, an overabundance of information contributed to difficulty in clarifying responses and added to unrelated tangents. When Nancy asked one patient why she had not been able to eat, she responded with a complicated explanation of a visit to the hospital emergency room for abdominal pains and frequent need to urinate. She was given an ultrasound and prescribed some medication which she had just finished taking. While taking the medicine, she did not take her prenatal vitamins, but planned to resume taking vitamins, which she thought would help her to eat and gain weight (week 3, 155-
163). Interpreting for Gretchen and a new patient, the researcher was unable to determine how advanced the patient’s pregnancy was. When asked what she was told at the emergency room, the patient responded that they told her she was thirty-six weeks pregnant. The information Gretchen had indicated thirty-two or thirty-four weeks of gestation. In clarifying the discrepancy, the patient explained that she had gone to the emergency room, was surprised by the diagnosis of pregnancy and was advised by a family member to seek a second opinion from another doctor. The patient explained that the family member in question had seen the doctor for a second opinion regarding a different medical condition. The second opinion confirmed the diagnosis of advanced pregnancy, but placed the gestation at thirty-two to thirty-four weeks instead of thirty-six weeks (week 4, 1254-1263).

A lack of sufficient information also interfered with communication at times. Beth said that sometimes when she asked if everything was alright at the end of the initial interview, she could “pick up that maybe they didn’t tell me something…and they’ll just tell me what they think I want to hear to get them through the interview because they know the next step is seeing the provider and that’s when they’re really going to save up and spill everything” (interview 2, 84-89). Kim reported similar experiences of patients who reported no nutritional problems to her when in reality they were struggling with a nutrition-related problem. She cited the example of a patient who said “no” when asked if she were having any problems with breastfeeding. The interpreter arrived and reported to Kim that she had been working with the patient on breastfeeding because she had “all kinds of problems” (interview 2, 875-878).
In some cases withholding information might have simply been efficiency on the patient’s part. If they knew they would probably have to repeat everything in a different part of the visit, they cold have been trying to save time. Their reluctance to attempt to communicate with the English-speaking health care professionals might have also demonstrated an over-reliance on interpreters. Bernice often had the experience of patients looking to interpreters for explanations that she was capable of—in one case seeking an interpreter when one was not already present only to find that Bernice was able to understand and answer the patient’s question (week 4, 493-502). Through interpreting, the interpreter could also interfere with reciprocity in the same way by assuming the patient required interpreting. The researcher experienced this when a nurse pantomimed listening and measuring while explaining in English that they were only going to listen to the baby’s heartbeat and measure her abdomen in that visit—something that happened in virtually every visit. The interpreter explained in Spanish, “van a escuchar el latido del corazón y medirle,” and the patient made it clear that interpretation was not necessary when she responded, “sí, yo sé que van a escuchar el latido del corazón y que me van a medir” [yes, I know that they are going to listen to the heartbeat and that they are going to measure me] (week 4, 163-168).

The above discussion demonstrated that in general there was a mutual desire to communicate within the clinic setting that was indicative of reciprocity. The problems that interfered with reciprocity cannot be separated from issues of language and power, a topic that will be addressed in greater detail in the following section.
4.9 Research question 7: What power dynamics related to language of communication are at work in providing client services?

A. How do the power dynamics differ according to an individual’s role in the clinic?

B. How do the interactors cope with power dynamics?

The participants in this study demonstrated an understanding of the importance of linguistic flexibility, cross-cultural understanding, and cross-linguistic communication. Nevertheless, English was undeniably the discourse of power in the clinic setting. The lack of value placed on multilingualism in the broader context of the United States was reflected in the clinics. The participants genuinely wanted to learn Spanish in order to communicate with Spanish-speaking patients, yet more importance was placed on the need of the patients to learn English.

A diffusion-of-English paradigm (Skutnabb-Kangas, 1996) was in place in the clinics, which was consistent with the attitude of the surrounding social system. Skutnabb-Kangas (1996) advocated an ecology-of-language paradigm, which promoted equality in communication, multilingualism, and language maintenance. However, Skutnabb-Kangas was referring to worldwide English language education. In this study, foreign language education was the focus of the participants, which is a clear step in the direction of an ecology-of-language paradigm.

In the clinics where this study was conducted, English was the language that conferred power—the power to understand and be understood, as well as to be known on a personal level. When discussing the importance of being able to verify patient understanding, Kim said she felt that patients sometimes answered “yes” when asked if they understood how to use the food coupons she gave them, but then left without
knowing how to use them. She wondered if they had adjusted to having to leave confused and frustrated, knowing that they would have to figure things out on their own (interview 2, 252-258).

The fact that non-English speaking patients were sometimes forced to complete communicative interactions without understanding meant they did not always know important information about their own medical care. During one postpartum visit, Bernice struggled to find out if the patient had received a vaccination or a birth control injection at the hospital so that she could determine if the patient should get an injection at the clinic that day. The patient only knew that she had received an injection in the hospital. Bernice was able to narrow the possibilities by describing some differences between the two injections (week 5, 251-278). During her work-up interview, another patient answered that her baby was not moving enough. It was determined that she had gone to the hospital where tests had been done to determine that the baby was well. The patient presented the nurse with a folded yellow scrap of unlined paper that she had been given at the hospital, where she was told to bring the note to her next visit at the clinic. The yellow paper had “F/UP next visit” written in pencil, which simply meant “follow-up next visit” (week 2, 727-740). The simplicity of the note, written with abbreviations those outside the medical profession would not understand, seemed to indicate a lack of clear communication at the hospital. Presumably, where an ability to communicate existed, the patient could have been told to follow up at her next regular clinic visit. Likewise, a patient who had received an injection would know what shot she had received.
Because of mutual understanding, Beth was able to establish a personal relationship with English-speaking patients, but not Spanish-speaking patients. She said, people who speak English, I end up chatting with more about little sideline things—their kids,...all different social factors affecting their pregnancy—more than I do with the Hispanic patients. Sometimes I don’t feel like I know them as well as a person, just because...I don’t get a lot of the stuff about their family and their kids and...their boyfriend’s job and...that kind of stuff (Beth, interview 2, 231-240).

Beth recognized this as a flaw in the socio-linguistic system of the clinics. She could help an English-speaking patient with problems such as domestic violence, housing issues, and billing problems by referring her to a social worker. She did not even find out about such problems with her Spanish-speaking patients, who might have had more complicated issues to deal with:

I’m sure the same things are going on with the Hispanic people and probably sometimes worse because sometimes they’re not in the country legally, the don’t have...a driver’s license, but they’re out there driving a car and they get in an accident and then they get taken to jail and sent back to where they came from and now this woman who is pregnant is here all by herself (interview 2, 252-257).

Despite a perceived inability to communicate about social issues, social power was exerted over the Spanish-speaking patients, as manifested in the issue of birth control. In the discussion of birth control in section 4.7.1.2 above, it was stated that some patients accepted the first birth control injection because they viewed it as an expectation of the clinic staff, but never returned for follow-up injections (Beth, interview 1, 566-572; Bernice, interview 1, 940-942). Bernice said she tried to ask the patients if they were interested in some information, and told them that they were “the bosses of their bodies” [la jefa de su cuerpo] to emphasize that the decision belonged to the patient alone (interview 1, 931-937; interview 2, 257-266). While Bernice felt she was not doing her
job if she did not at least offer them information, she also felt that the options made available through the clinic might have fallen short since so many women seemed to be giving in to pressure when they accepted the first birth control injection. She asked, “wouldn’t it be better to talk about something…like the rhythm method?” (interview 1, 939-955), an option that is not discussed in any of the literature available at the clinic.

From a position of linguistic and social power, it was easy to apply conditions to issues of reciprocity. It was important to some of the staff that while they tried to learn Spanish, Spanish-speaking patients also were trying to learn English. Nancy stressed the importance of reciprocal learning when she said “it’s important…to keep in mind the patients, too, and that element of helping them to be willing to try and learn as well” (interview 1, 783-784). She thought that by using Spanish the staff were acting as role models for the patients who were “reluctant to work on English” (interview 1, 328-336). Later she added that “it’s more important for them to be learning some English, even than it is for me to be learning Spanish. I can get an interpreter, I can get by, but they’re living in an English-speaking country” (786-789). When a patient was concerned with how quickly an interpreter would be available when she went to the hospital to deliver her baby, one nurse reassured her that an interpreter would be almost immediately available, but followed up with the suggestion, “or you could learn English…I’m learning Spanish” (week 2, 428-433).

In addition to the clinics, Kim worked in an environment in which no interpreters were available. She noted that in such a setting there was a dominant sense that it was the obligation of the non-English speakers to learn English, with no sense of the
importance of multilingualism. Kim said when people reacted to their English not being understood by repeating the same things louder and louder, she wanted to say, “well, it’s not that they can’t hear you” (interview 2, 212-214). She also noted the double standard of “that constant, ‘do you understand?’” addressed to non-English-speaking patients—who often answered “yes” whether or not they understood, while understanding was assumed on the part English-speakers (interview 2, 229-232). From that experience, Kim had made an effort to find different ways to say things when she was not understood (interview 2, 216-232).

As the above discussion made clear, by virtue of being the professionals the clinic staff had more power than any of the patients in the clinic setting, but especially those who did not have a command of the discourse of power. Another power dynamic came in to play at the level of the interpreters, who theoretically had the power to broker all communication between native English-speakers and native Spanish-speakers. In its simplest form, interpreting offered an informed, objective, disinterested alternative to no communication at all or communication facilitated by a patient’s friend or family member (Gretchen, interview 1, 230-238). Such an informed, objective, disinterested perspective was an important one to have for the only person who could understand everything everyone in an interaction was saying. Being the third party in a conversation, but the only one who could understand and speak both languages (Bernice, interview 2, 27-29), put interpreters in a powerful position. In many cases, the interpreter traveled with the patient through her clinic visit and therefore had all the pieces of information, while other staff members were only party to certain portions of the visit. From the patients’
perspective, having an interpreter empowered them to be able to get more thorough explanations (week 3, 332-340; week 5, 482-487), clarify something they did not understand (week 6, 114-118), and answer questions with more than a yes/no response (week 2, 1106-1109).

While in theory, and sometimes in practice, the interpreters wielded significant communicative power, the following discussion will problematize the issue of interpreters’ power as it is examined in terms of how the various interactors in the clinic setting coped with power dynamics. Because practitioners were the authorities with the most expertise, it was easy for them to establish power over the interpreter even as they relied on interpreters to communicate with patients. Though the researcher did not observe frequent examples of this, her authority as interpreter was challenged by practitioners.

In one case, a practitioner who did not normally use interpreters with Spanish-speaking patients because she had studied Spanish asked the researcher to interpret during an exam. The practitioner communicated directly with the patient using both Spanish and English, engaging the interpreter only to fill in gaps in her Spanish or explain certain aspects of the visit. The researcher was not empowered to interpret the visit as a whole nor to voluntarily assist communication, but rather was there for some other purpose known only to the practitioner. The researcher had to interrupt when the practitioner told the patient, in Spanish, to get a birth control injection before [antes] the baby was born instead of after [después]. The researcher felt compromised both by having been asked to interpret for someone who normally did not use an interpreter and
by having an experience that indicated that the practitioner probably should have been using interpreters (week 4, 1635-1660).

In another instance, a practitioner gently reprimanded the researcher for not interpreting her greeting to the patient. The practitioner had greeted the patient and added a comment about the patient’s daughter: “with her pretty little girl and her pretty barrettes in her hair.” As the practitioner washed her hands, she looked over her left shoulder at the interpreter and explained that she liked to greet patients with a little small talk, such as her comment about the patient’s daughter being pretty. As she dried her hands, she leaned over toward the girl and said, “muy bonita,” then she walked over to the patient’s chart, open on the counter, and said to the interpreter, “that way it doesn’t seem so cold and clinical” (week 2, 1162-1184). As the practitioner had demonstrated through her interaction, she was capable of conducting the small talk without the interpreter, something that made the interaction significantly less “cold and clinical” than if it had been left for the interpreter to do for her. By leaning over and engaging the child, she proved she was interested in her and not just commenting on her.

While the researcher did experience uncomfortable power dynamics in a few situations with practitioners, more often the interpreters were bestowed power beyond their roles as interpreters. To avoid repetition, the interpreter sometimes took—or was given—communicative control. Rather than acting as an interpreter, repeating the English-speaking professionals’ questions in Spanish and repeating the Spanish-speaking patients’ answers in English, the interpreter might have been expected to act on the professionals’ behalf in conveying familiar information to Spanish-speaking patients. As
Bernice explained it, “the interpreters are usually around a lot and they know the program…so to have to be a true interpreter…seems like an insult to [the interpreter] and a waste of me talking more” (interview 1, 335-341). Bernice offered the three-hour glucose tolerance test for gestational diabetes as one example. Because the interpreters were familiar with the in-depth explanation, the health care professionals might have said “explain the test” instead of actually explaining it in English each time and waiting while the interpreter repeated everything in Spanish.

Kim gave the example of explaining the food coupons, saying that she told the interpreters to explain the coupons, but did not actually explain it herself in English each time (interview 2, 816-819). Kim repeatedly asked the rhetorical question, “how boring would that be?” in reference to the hypothetical situation in which the interpreters had to strictly interpret only what was said in English, even when they knew the information and could produce it in Spanish without hearing it in English first (802-819). Gretchen stressed that the health care professionals relied on the interpreters’ familiarity with the process and the content to help “cut to the chase with the patient” (interview 2, 247-260).

In acting as interpreter, the researcher became familiar enough with content to be able to quickly and efficiently conduct an initial interview in Spanish without interpreting from the English (week 5, 987-999). After months of watching medical students misplace the gel on patients’ abdomens and listen for their babies’ heartbeats in the wrong place while smearing gel over larger and larger areas of the patients’ abdomen, the researcher intervened with one medical student in her last week of data collection. As the medical student put gel directly to the right of the patient’s navel, the researcher stepped
over to stand next to the medical student and said, “it’s almost always here or here,” pointing to lower right and lower left abdomen. The researcher immediately apologized, explaining that her knowledge was a result of interpreting in so many exams. The researcher offered no further information to the medical student, even when it was solicited and stayed through the exam with the attending doctor, who taught the medical student about the baby’s heartbeat (week 7, 164-175).

As the above examples demonstrated, interpreters enjoyed a position of power in the clinic setting. However, in the most literal sense, bilingualism was not valued. The interpreters did not have any medical interpretation training and as the least educated staff, one can only assume they were also the lowest paid. Kim reported seeing a job posting for a Spanish-English bilingual dietician. She commented that bilingualism was a “pretty big requirement” over and above the field-specific training—especially given that she would have had to take a pay cut to accept the job (interview 2, 715-725). In addition to undervaluing the bilingualism of interpreters, the advertisement Kim saw implied the industry was seeking to employ bilingual professionals without compensating them for their bilingualism. Taken to its logical conclusions, such a trend would threaten the jobs of the interpreters. Nancy alluded to this phenomenon in her second interview when she said that she knew the interpreters were willing to help her with her Spanish, but that she was reluctant to solicit their help because “the more they help me, then the less I need them and that…directly can effect their job” (94-97).

Though patients were not participants in the study, the researcher was able to make some observations of their coping with power dynamics in the clinic setting.
Patients were observed combating their own lack of power in the clinic context with a sense of humor as well as through resistance. While going over a patient’s chart in an exit interview, Bernice told a patient she had to consume more calcium-rich foods and beverages [tiene que tomar más comida y líquidos con calcio]. The patient laughed and Bernice exclaimed “she’s laughing at me!” Acting as interpreter, the researcher clarified that the patient was laughing at the content of what Bernice had said. Bernice acknowledged that in the clinics the dominant view was widely-imposed, saying, “damos mucho advice*…tenemos ideas estúpidas” [we give a lot of advice…we have stupid ideas].

A patient might also cope with power imbalances by demonstrating her fluency in English. After a nurse explained in English and pantomimed what would happen in that day’s visit, the researcher unnecessarily interpreted for the patient, who made it clear interpretation was not necessary by saying she knew what they were going to do: “sí, yo sé que van a escuchar el latido del corazón y que me van a medir” [yes, I know that they are going to listen to the heartbeat and that they are going to measure me] (week 4, 163-168). In another case, after the researcher interpreted various parts of her visit, a patient stood up to leave and said in flawless English, “thanks so much” (week 2, 250). The researcher and health care professional were surprised by the fluency with which the patient colloquially offered her thanks. The researcher wondered if she had made a fool of herself by unnecessarily interpreting for the patient, but the patient was the only one who knew whether that was the case or not.
Nancy commented that she did not understand the rare patient who exhibited a “refusal to understand any English, or, or say my attempts at Spanish. It’s almost like they just look like ‘what are you talking about?’ and refuse to even attempt until you get an interpreter” (interview 1, 239-246). It may have simply been that the patient chose to cope with power dynamics by demanding the interpretation services to which she was legally entitled. At times, patients seemed to withhold information when an interpreter was not present. Beth reported that patients sometimes responded “yes” when she asked them if everything was okay, but they really had a problem that they waited to discuss until the exam, where an interpreter was present (interview 1, 477-489; interview 2, 80-89). Such tactics may have been used simply to avoid lengthy repetitions, as patients familiar with the process knew they often repeated the same things in the work-up interview, in the exam, and again at the exit interview. Kim talked about similar situations in which patients reported no nutrition-related problems to her, but discussed their problems at great length with the interpreter. Kim concluded that it was worth having an interpreter present if it meant more open communication with the patient, even if Kim herself felt she did not need an interpreter (interview 2, 869-880).

Sometimes a refusal to communicate meant answering with a false “yes,” as was discussed above in terms of reciprocity. Though possibly exerting power, or at least coping with a power imbalance, some kinds of refusal might have resulted in patients leaving without understanding important information about their own health.

Though clear power imbalances existed in the clinic setting, it could not be denied that the health care professionals’ attempts at using Spanish, combined with the Spanish-
speaking patients’ attempts at using English empowered all parties to communicate across their linguistic and cultural barriers. Nothing made this more clear than when a health care professional encountered a patient from a language background other than Spanish who did not speak English. Nancy despaired of such situations, saying “it is amazing how little you can…I mean if you can’t ask somebody if they’re having pain, if they feel bad… and they can’t say anything to you…you can’t get anywhere. So you realize that even a little bit of language actually goes a very long ways…when you’re not needing to have a philosophical discussion about something, but you’re trying to get something accomplished” (interview 1, 723-734). Through their mutual perseverance in the clinics, the patients and health care workers truly had accomplished a lot. Just as native-speaking proficiency in English might not be the goal of the patients, the health care professionals learned Spanish exclusively for use at work. Though it was not without power imbalances, a multilingual society had emerged in the clinics that were the setting for this study.
CHAPTER 5
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Now having presented and discussed the results of the study, this final chapter will draw conclusions from the relevant data presented in the previous chapter. The chapter begins with a summary of the results of each research question. The conclusions follow, organized in a manner that addresses conclusions drawn from the results of each research question. A discussion of syllabus design implications for Spanish for medical professionals and relevant strategy instruction concludes with the presentation of a proto-syllabus. Finally, the chapter concludes with a discussion of possible areas for further study and reflections on the research process.

5.2 Summary

5.2.1 Research question 1: What is the nature of communication between health care professionals and patients in a perinatal clinic when the two parties do not share a native language?

Communication in the perinatal clinics took one of three general forms: unable to communicate, able to communicate, or aided communication. An inability to communicate resulted when the health care professionals’ Spanish together with the patients’ English was not enough to convey a complete message. This inability to communicate was often the result of not knowing enough of the other person’s language.
to understand the details of the message. An inability to communicate did not persist in the clinics because there were interpreters working in the clinics.

The resources—used in various combinations—that enabled communication in the clinics included interpreters, the health care professionals’ Spanish together with the patients’ English, written resources, and gestures. Many staff chunked interactions with Spanish-speaking patients so that they could call in an interpreter at the end. Some staff liked to try to communicate in Spanish with an interpreter present to ensure that it was correct. Using the staff’s Spanish with the patients’ English involved negotiating each others’ skill level and a lot of mixing of the two languages, with ample gesturing and pantomiming to further facilitate communication. Written resources were used both to enable the staff’s production of Spanish and as a means to distribute information to the patients.

Assisted communication consisted of using the interpreter in the traditional role of repeating the staff’s words in Spanish and the patients’ words in English. The interpreter was needed in the traditional role when addressing topics important to a patient’s plan of care, for in-depth explanation, and for situations that required strong listening skills, such as interactions heavy with dialogue. Sometimes assisted communication was interrupted when the interpreter misunderstood or misstated information. At other times assisted communication was punctuated by understanding between the health care professional and patient without need for interpretation—usually because the health care professional either understood the patient’s or the interpreter’s Spanish.
5.2.2 Research question 2: In learning Spanish on the job, what linguistic structures are acquired by health care professionals?

The interpreter also repeated the English words of the participants in Spanish, rendering the Spanish content familiar. An interpreter’s presence freed the participants from having to try to produce spoken Spanish so they could focus more on listening.

5.2.3 Research question 3: In learning Spanish on the job, what are the processes through which the acquisition of linguistic structures takes place?

Various processes were employed by the participants in this study to acquire language on the job. The strategies observed by the researcher or mentioned by the participants in their interviews included pursuing specific terms—by asking an interpreter, looking them up, or repeating a key word that was understood—attempting to create with the language, hypothesis-testing, making use of background knowledge, rephrasing, and referring to or constructing written materials.

5.2.4 Research question 4: What are the linguistic needs of the English-speaking health care professionals in the perinatal clinics?

While each participant in the study had individual linguistic needs, seven common areas of linguistic need were identified. To improve beyond their current levels, all participants felt they needed instruction, either informal on-the-job training or formal classroom instruction. The data showed a need for basic pronunciation skills, a guide to which is available in various published materials for health care professionals. Telephone conversations proved an area of need because the interlocutors could not rely on paralinguistic cues and because often the patients were initiating the phone call and consequently controlling the conversation—something that the health care professionals normally did. In order to get to know Spanish-speaking patients better, the participants
needed more social-psychological communication skills. To use the language beyond
basic memorized scripts, the participants required a sense of Spanish grammar, especially
verbs. Some basic grammar instruction might allow them to create with the language
using the fixed lexical items and expressions as a starting point. Written resources were
important, though unless they were designed to provide information to the patients, it was
important to have the relevant information from the written resources formatted
according to the specific purposes of the individual health care professional. Listening
skills proved to be a particularly important need, primarily because of the imbalance that
was created by the participants possessing seemingly proficient production skills and the
difficulty of acquiring listening skills through rote memorization.

5.2.5 Research question 5: What are the cultural needs of the English-speaking health
care professionals in the perinatal clinics?

In their interviews, the participants demonstrated a metacognitive awareness of
the culture of their workplace. The awareness and understanding of their own culture
gave the participants a good starting point for understanding other cultures represented in
the clinic setting. The participants found great similarities across cultures because all
their patients were pregnant women concerned about their health and the health of their
babies.

Despite the general similarities, there were specific beliefs and customs that
varied with the Spanish-speaking patients. Many Spanish-speaking patients preferred to
wait until their milk came in to breastfeed their children rather than trying immediately
after the baby was born, as is customary in U.S. hospitals. The infrastructure of the
clinics was such that patients were expected to use birth control to prevent pregnancy in
the first year after the birth of their baby, a custom that Spanish-speaking patients did not always comply with, sometimes covertly rejecting the birth control by getting one injection, but not following up with a second shot. The Spanish-speaking patients often had family accompany them to appointments and participate in their health-related decisions. The Spanish-speaking patients were possibly less interactive with the health care professionals than their English-speaking counterparts, but the language barrier presented an intervening factor in the ability of both parties to interact. Spanish-speaking patients tended to eat their largest meal in the middle of the day, with smaller early and late meals or snacks. Some participants perceived a difference in attitude toward poverty between Spanish-speaking and non-Spanish-speaking patients, manifested in placing less importance on short-term material gains, such as clothing and other small consumer items, in order to focus on long-term material gains, such as home ownership. The researcher observed that the interpreter’s role in the clinic setting was not a culture-free one and that there were advantages and disadvantages to both native and non-native speaking interpreters.

Important cultural differences at the linguistic level also emerged from this study. In some cases, the health care professionals were able to use words translated from English to Spanish, but the cultural ramifications of their meanings had not been translated, resulting in occasional confusion and miscommunication. The follow English words and their Spanish translations were examined in terms of the cultural ramifications of linguistic transfer: fluid, Pedialyte, food, one week, bills, to suffer, to deliver, enough, and to go to the bathroom.
Research question 6: Is there reciprocity between the English-speaking health care professionals and their Spanish-speaking patients in their attempts to communicate in the clinic setting?

Generally, there was reciprocity between English-speaking health care professionals and their patients in the clinic simply because there was a mutual desire to communicate. The concept of “meeting halfway,” with each party using as much of her second language as possible to communicate, was essential to reciprocity. The participants negotiated with patients to keep responses short and concise, while the patients adjusted their speech and helped English-speakers with their Spanish language skills. The health care professionals used both English and Spanish to convey information to their patients, while trying to accommodate each patient’s language preferences.

Some problems were found that interfered with reciprocity. Some participants reported difficulty assessing patient receptivity, suspecting that an affirmative answer did not always mean “yes.” A lack of social-psychological uses of language prevented patients and health care professionals from getting to know each other personally. Only occasionally did there appear to be an unwillingness to try to communicate across languages. As in any communicative setting, sometimes there were incidents of unintentional over- or under-simplification of information.

Research question 7: What power dynamics related to language of communication are at work in providing client services?

A. How do the power dynamics differ according to an individual’s role in the clinic?
B. How do the interactors cope with power dynamics?

Given the basic monolingual context of central Ohio, perhaps it is not surprising that in the clinic setting, the need for the patients to learn English was emphasized over
the health care professionals’ need to learn Spanish, demonstrating the power differential between the two languages. In the clinics, English conferred unencumbered power to understand and be understood. It was often expected that the non-English-speaking patients would study English, especially if the health care professionals were making an attempt to study another language. Social power was also exerted over all patients, English- and Spanish-speaking alike, as demonstrated in the proliferation of birth control education.

The practitioners’ role in the clinic operations put them in the position of greatest power, but the interpreters also wielded power in terms of being the only ones who could understand everything in many interactions. However, in a literal sense bilingualism was not valued as a skill worth paying for.

Patients coped with power dynamics with a sense of humor, by demonstrating a knowledge of English, or by demanding interpreting services.

5.3 Conclusions

5.3.1 The nature of communication in the clinic setting

The health care professionals in this study needed Spanish for cognitive-informational purposes—specifically, to interview patients--more than for social-psychological purposes such as spontaneous conversations. To say that a simple ability or inability to communicate persisted in the clinic setting would be an oversimplification. For the participants in this study, discussions that strayed from the basic scripts used to interview patients resulted in an inability to communicate. Often the discussions that strayed from the script included social-psychological purposes for communication.
Details such as phonetic differences between similar words and prefixes also interfered with communication. An inability to communicate also resulted when patients answered inquiries with more than one word answers such as the following: “sí,” “no,” “poquito,” numbers, time and date references, or colors. For production, that meant anything beyond the basic script and for reception it meant anything more than a word or two.

Dividing interactions into two portions—one that could be done without the interpreter using the patient’s English, the health care professional’s Spanish, gestures, and written resources and one that required interpreting—enabled communication. The prepared scripts were the resources that most enabled independent communication on the part of the participants. However, the proficiency with which the participants were able to produce script items sometimes interrupted communication because patients assumed equal receptive abilities, which most participants did not have. Though the participants had access to input when interpreters communicated with patients in Spanish, the input processing model might not apply in this setting because the imbalance between reception and production meant that production might not have resulted from hearing the spoken language, understanding it, and developing an understanding of the grammar.

The presence of interpreters also allowed for aided communication in the clinic setting. For the participants in this study, all of whom were trying to learn Spanish, it was important to be aware of their patterns of communication. Communicative efficiency was increased by knowing when independent communication could occur, when an interpreter would be needed and planning interactions accordingly.
5.3.2 Language acquired on the job

The participants in this study had been able to independently acquire fixed lexical items and expressions to use in the presentational mode of communication in routine patient interviews in a clinic setting. Participants were less able to independently acquire receptive skills in Spanish. Their understanding of spoken Spanish was mostly limited to one- or two-word replies such as yes/no responses and references to family members, numbers, days, time, and colors.

In terms of pedagogical implications for Spanish for medical professionals, these results indicated that rather than using valuable class time focusing on direct instruction in producing profession-specific vocabulary and expressions, a focus on understanding spoken Spanish might be more useful. For purposes of speaking, students might be referred to published resources and helped to synthesize that information into a format that would be useful at work, such as typed lists of questions or notecards. During the study, the researcher was able to use such an approach. She worked with the staff to prepare a postpartum interview script that they used to increase the range of interactions they could independently complete in Spanish. The participants’ lack of receptive Spanish-language skills suggested a need to focus on listening comprehension abilities in a Spanish course for medical professionals. Possible approaches to doing so are discussed below in the section on syllabus design implications.

5.3.3 Language acquisition processes

Grenfell (2000) provided a list of important strategies for acquiring a language. They included “learn by heart phrases” (p. 14), “strategies for committing familiar

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language to memory” (p. 14), “develop…independence in language learning and use,” (p. 14) “use dictionaries and reference materials” (p. 15), “use context and other clues to interpret meaning” (p. 15), “understand and apply patterns, rules, and exceptions in language forms and structures” (p. 15), “use…knowledge to experiment with language” (p. 15), “understand and use formal and informal language” (p. 15), and “develop strategies for dealing with the unpredictable” (p. 15).

Most of Grenfell’s strategies were used by participants in this study without the benefit of formal instruction. The participants in this study had all acquired many learned by heart Spanish words and phrases. The widely used scripts were an important strategy used in the clinics to commit familiar language to memory. The participants in this study demonstrated independent development of important strategies such as hypothesis-testing and deployment of background knowledge. Nancy and Gretchen demonstrated an awareness of their own learning style as attested by their dependence on visual learning. All five participants used dictionaries and reference materials in Spanish. Most dealt with the unpredictable by dividing their interactions with Spanish-speakers into two parts—one predictable and one unpredictable.

The strategies suggested by Grenfell that seemed to be lacking in the clinic setting included an ability to understand and use formal and informal language, an ability to experiment with the language, and an ability to understand and apply patterns, rules and exceptions in language forms and structures. Participants did not consistently distinguish between the informal second person singular, “tú,” and the formal second person singular, “Usted,” when addressing patients in Spanish. With the possible exception of
Bernice, the participants did not understand the linguistic system well enough to create with the language. Possibly because the participants functioned in Spanish by memorizing fixed expressions for productive purposes and understanding only a few isolated spoken words for receptive purposes, the comprehensible input model of input -> intake -> developing linguistic system -> output did not apply in the clinic setting.

An important listener strategy that seemed to be lacking in the clinic setting was the ability to rephrase or solicit repetitions. Development of listening strategies was particularly important to the participants in this study because their deceptively fluent speaking did not reflect their limited listening capacity. This imbalance also demonstrated that the comprehensible input model did not seem to apply. The fact that output did not seem to aid their ability to develop a linguistic system might indicate that the complementary comprehensible output model also did not apply to this population of learners. For this group of learners, output seemed to be the starting and ending point in terms of language acquisition.

Grenfell noted that successful learners were “active and positive about their language learning, building up a base competence which they developed over a period of time” (p. 12). The language-learners in this study were all active and positive, but they seemed to lack a Spanish communicative base competence. This lack of a base competence points to some important linguistic needs on the part of the study participants. All of the needs should be subjected to further study and analysis.
5.3.4 Linguistic needs

The need for more basic conversation skills to use for social-psychological purposes highlighted the discrepancy between possessing abilities to complete workplace functions and lacking beginning and intermediate abilities to participate in basic conversations. While all the participants could conduct relevant medical interviews in Spanish, they could not engage their Spanish-speaking patients in social conversations about their lives and experiences outside the clinic setting.

The need for an understanding of grammar and the fact that participants were able to acquire enough productive skills to say almost everything they needed professionally without commensurate acquisition of receptive skills also showed that despite significant productive abilities and exposure to the spoken language, no linguistic system seemed to develop as the comprehensible input/output models would suggest occurs during the language acquisition process. Part of the reason for this might be that the English-speaking medical professionals were usually in the interlocutor role of interviewers, which differed from a natural setting in which a learner would be in various, frequently-changing interlocutor roles.

Advocates of the comprehensible input model might attribute the lack of understanding the second language system to participants’ productive abilities, claiming that early production distracts learners from the important “L2 system manifested in the input that he or she hears” (Grove, 1999, p. 818). However, that would be an oversimplification of the present case, given that the participants in this study were not without input nor early opportunities to be exposed to it. They also appeared to benefit
from comprehensible output, even though it did not contribute to an understanding of the second language system. Among advantages of comprehensible output enjoyed by the participants in this study were that it provided “the opportunity for meaningful (contextualized) use of one’s linguistic resources in the process of negotiating meaning” and “opportunities to test out linguistic hypotheses to see if they work” (Grove, 1999, p. 819). Swain also noted the important “noticing/triggering function of output” which “has a consciousness-raising effect that focuses learners on ‘gaps’ or problems in the ways they conceptualize the L2 system” (Grove, 1999, p. 819).

The participants were observed using output to negotiate meaning, test linguistic hypotheses, and determine gaps in their own language acquisition. They used strategies such as rephrasing what the patient said to check for understanding, circumlocution to communicate words or ideas that they did not know how to discuss directly in Spanish, and requests for repetition. When participants used interpreters to check their understanding, they had the opportunity to think out loud about word meaning and usage. All participants mentioned in formal interviews and informal discussions in the clinic their need to know how to use verbs as more than lexical items. They suggested that a better understanding of verb conjugations might provide a sense of grammar that would allow them to create with the language. Bernice specifically mentioned her concern that she might offend patients by mixing the formal [Usted] and informal [tú] registers when addressing patients in the second person. Nancy and another nurse solicited clarification from the researcher on explicit use of subject pronouns—something that is required in English grammar, but not in Spanish grammar.
The working health care professionals in this study needed more input and more strategies for dealing with input, but another area of need was explicit grammar instruction to provide an understanding of the second language system. Deductive presentations of grammar might complement the potential for inductive learning on the job. For example, an explicit grammar lesson on the formation of the future $ir + a +$ infinitive allowed the clinic staff to communicate any future action with the patients. Then they may recognize that and similar structures as used by patients and interpreters so that they learn the structure from the explicit explanation together with exposure in a natural setting. Any formal instruction would have to account for the fact that the working professionals in this study did not have time or resources to study language for the sake of studying language. These working professionals needed to learn language on the job, even if that coincided with formal instruction directed toward working professionals. Any course for language professionals should account for on-the-job learning and integrate it into the curriculum.

5.3.5 Cultural needs

At the start of the study, the researcher anticipated finding significant cultural differences between the Spanish-speaking patients’ attitudes towards and beliefs about medical care and the medical care that was provided in the clinics. However, overtly teaching discrete cultural differences would not be an effective approach to teaching culture to professionals who work with Spanish-speakers. It would be difficult to know exactly which cultural practices were relevant without extensive research in the setting. Stereotypes might be inadvertently taught by over- or under-emphasizing cultural
differences. Instead, students could be referred to published materials that could be discussed in terms of their relevance to the workplace setting. Ríos and Torres (2001) provide a thorough and informative chapter on cross-cultural communication in their book *Medical Spanish: The practical Spanish program for medical professionals*.

While it is important to know specific cultural practices of other cultures, more important is a recognition that cultural differences exist. Medical professionals learning about the culture of Spanish-speaking patients should develop the habit of thinking about how things might vary culturally, then research them appropriately by reading or talking with various people who might know, bearing in mind that no one person can ever represent an entire culture.

In his discussion of intercultural competence in teaching English as an International Language, Alptekin (2002) suggested that native speakers might not be the best cultural representatives when dealing with both global and local contexts. Spanish-speaking patients in the United States might not have the same cultural practices as Spanish-speakers in their home country, yet their practices still might differ from those of the English-speakers in the United States. Alptekin suggested that pedagogic models should be based on “successful bilinguals with intercultural insights and knowledge” (p. 63) rather than specific language and culture backgrounds that may prove irrelevant to or ineffective in a given pedagogical context.

Reflecting on one’s own culture is an important first step in cross-cultural understanding. Students should be encouraged to think about their own culture as well other cultures. After the workplace culture is observed by students, the teacher or both,
the observations should be discussed in terms of how such an environment might be perceived by an outsider. Possessing cultural information and awareness should aide effective cross-cultural and cross-linguistic communication (Alptekin, 20002, p. 63).

For the language teacher, the cultural connotations inherent in language are an important aspect of culture to address. Not only is it important to teach students how to say something in another language, it is also important to teach how the “same” words in another language may convey different meanings.

5.3.6 Reciprocity

In the clinic setting in which this study was conducted, there was a widespread commitment to communicate. The staff’s use of rudimentary Spanish combined with the patients’ use of rudimentary English, together with early negotiation of each other’s second language skills, was considered reciprocity. Both patients and the health care professionals adjusted their speech to accommodate their interlocutors.

A lack of reciprocity was attributable to too much information provided in the interlocutor’s second language, not enough information provided to convey the message, or a misjudgement of an interlocutor’s language skills. Reciprocity was also impacted by the complicating cultural issue of Spanish-speaking patients not wanting to challenge the authority or waste the time of the health care professionals by asking questions. The best way to determine that a patient had understood directions was to ask specific, direct questions, such “when are you going?,” “what are you going to take and how often?,” the answers to which would indicate that the patient understood. Global questions, such as, “do you understand?” were not effective in determining whether a patient understood.
5.3.7 Power dynamics

Where professionals need a second language to communicate for business purposes, language intended for social interaction can be important. As Thorogood (2000) pointed out, “at many levels of work-responsibility [it] is a vital element in the transacting of business” (p. 139). The results of this study indicated that language intended for social interaction was widely absent from the health care professionals’ repertoire. Nancy repeatedly expressed a desire to learn to use Spanish in a non-medical context. Beth cited her inability to get to know Spanish-speaking patients in the same way she was able to get to know English-speaking patients as a weakness since it meant she did not learn about social factors affecting their pregnancies. Despite her abilities at work, Bernice did not feel equipped to function in Spanish as she traveled and dined during a trip to Mexico. The lack of ability to communicate for social-psychological purposes emphasized that English was the language of power in the clinic setting and that the onus fell on Spanish-speakers to learn English, especially for communicative purposes beyond basic medical care.

Grenfell (2000) suggested that social interaction was “very much dependent on a context where a high degree of target language is available as the natural medium of discourse” (p. 12). The participants in this study, and presumably anyone who needs Spanish for use in the workplace, had the advantage of being exposed to Spanish as it was naturally used. However, the fact that Spanish was only used for specific medical purposes in the clinic setting made it harder for the participants to acquire Spanish language skills for social purposes.
The interpreters, as the only functional bilinguals in the setting, had access to information and interactions that were unavailable to other members of the community. For example, they often when behind closed exam room doors to interpret for practitioners during exams. However, the limited role of interpreters in the clinics restricted their ability to report negative dynamics. For example, the researcher’s role was limited by the fact that reporting negative dynamics might threaten her position as volunteer interpreter and researcher in the clinics. Similarly, the paid interpreters wanted to protect their jobs as interpreters.

Despite power inequities evident in the clinic setting, the diffusion-of-English paradigm (Skutnabb-Kangas, 1996) was curtailed in the clinics, where foreign language education was a focus of the participants. Their interest, motivation, and progress in learning Spanish were clear moves toward an ecology-of-language paradigm.

5.4 Syllabus design implications for Spanish for medical professionals

Taking the various needs of the practicing medical professionals examined here into account in the design of a framework for language education requires flexibility. In the first place, the investment of time and money for these professionals should remain minimal. A coordinated effort with the health department could alleviate both issues if a joint funding effort were employed and an on-site location were chosen for once-a-week meetings throughout a ten-week course. For medical Spanish, methodological flexibility is also essential since it depends “on students’ learning styles and whether they are at a hospital setting or in a classroom” (González-Lee, 1998, p. 328). The ideal setting for this course would be a classroom set up in a clinic.
The syllabus design chosen for this particular population of medical professionals combined two perspectives. First, components of Krahnke’s task-based syllabus were incorporated into the proto-syllabus. Then elements of Yalden’s notional communicative syllabus design were integrated to create a negotiated syllabus, designed in line with constructivist theory. It offers enough structure to be recognizable as a syllabus to those accustomed to a traditional class, with its four essential parts: aims, content, methodology, and evaluation (Breen, 2001, p. 151), but it incorporates significant flexibility so as to be in line with a constructivist theory of learning.

Task-based syllabi are preferred by many ESP researchers (Bosher and Smalkoski, 2002; Breen, 2001; Gimenez, 2001) because they “focus on how language learning is undertaken” (Breen, 2001, p. 153). Breen (2001) specified two task types for use in task-based syllabi. Everyday tasks the learners carry out are communicative while tasks that involve talking “about how the language works or is used in target situations and/or sharing meaning about students’ own learning processes” are metacommunicative (p. 153). This emphasis on learning how to learn appears repeatedly in ESP literature along with admonishments that ready-made linguistic structures will not transfer to real-world situations. The tasks have to come initially from the learners’ real world situations. As Parkinson (2000) wrote, “skills acquisition should be deeply embedded in content” (p. 374).

Krahnke’s (1987) task-based syllabus stressed process over product (p. 11) with an emphasis on the real-world applications deemed essential--in this case, for medical professionals learning Spanish. Tasks are not static activities that students can carry out
through rote motions, but rather “involve a process of informational manipulation and development” (p. 57). In other words, students would seek out tasks in their professional context, bring those tasks to class and there work with the tasks, developing them into useful constructs applicable to their daily activities. Krahnke (1987) contended that “the language needed to carry out tasks is not provided or taught beforehand, but discovered by students and provided by teachers and other resources as the task is carried out” (p. 58). The communicative tasks encountered by health care professionals in perinatal clinics in this study are precisely the types of “tasks that the learners actually have to perform in any case” (Krahnke, 1987, p. 11). For example, the tasks that the participants in this study had to perform included interviewing patients at various stages of each visit, understanding patient responses to interview questions, explaining procedures, and giving directions.

Krahnke’s list of disadvantages of the task-based syllabus include its inappropriateness for teachers who are limited to traditional roles, the need for non-textbook resources, the problem of access to the target language, failure to meet student expectations of a language course, and the difficulty of evaluation by discrete-point tests. None of those problems would be factors in this case. Because it would be a non-degree program, there would be no need for discrete-point tests; alternative evaluation would be acceptable. The students have access to the target language and non-textbook resources and are aware that their needs fall outside the range of traditional language courses.

The teacher would be either someone acquainted with the students’ professional situation or someone with a background both in Spanish and the medical profession.
Crandall (1984) emphasized that the teacher should “not feel compelled to teach the vocation, but rather the ESP relevant to it” (p. 92). The issue of content knowledge on the part of teachers is always a factor in courses for specific purposes and while it is important to remember that language is the focus, content cannot be ignored. De Beaugrande (2000) suggested that content and language departments have to come together because their “traditional separation is frankly unaffordable at a time when the linguistic and discursive demands of the rapidly changing global economy are becoming explosively more complex and diverse” (p. 335). According to De Beaugrande, the language teacher’s focus on language pedagogy must be combined with resources from the content area in which the students study or work in order to provide effective specific-purpose language education. For this population of learners the needs assessment conducted by the instructor and the insights of the learners themselves, as practicing professionals, would go a long way towards achieving a balance between language and content.

Like the emphasis of process over product in Krahnke’s task-based syllabus, Yalden’s (1987) notional communicative syllabus stressed content over form. She specifically mentions this syllabus design as appropriate for professionals (p. 39). Yalden listed ten essential components of a communicative syllabus to consider in preparing a proto-syllabus (see also Graves’ framework, 1996, p. 25). These include the students’ purposes, the setting in which the language will be used, the students’ social role in the target language, the communicative events in which the language will be used, language functions, notions, discourse skills, the level aimed for, grammar, and lexicon (Yalden,
As the preceding analysis has shown, the students’ purpose is to communicate on a professional level with clients in a clinical setting about their health and health care needs. The important language functions for this population are listening and, to a lesser extent, speaking. The specific notions, grammar, and lexicon would have to be determined by the students as the course progressed.

According to Yalden (1987), the fully notional communicative syllabus is “suitable for learners whose proficiency in the second language has to be specified for very particular and essentially narrow purposes” (p. 115). Not only has this study limited the purposes to practicing health care professionals, but it has focused on those in perinatal clinics. The syllabus design, however, is flexible enough to apply to any specialized field of the medical profession, including physicians.

Yalden (1987), referring to the work of Stevick, states that “communication means the resolution of uncertainties” (p. 47). The proto-syllabus presented below aims to help students do precisely that. Resolving communicative uncertainties will involve constant negotiation. In a negotiated syllabus, students learn to learn and then apply the process outside of the classroom context. This process of learning to learn, of constantly negotiating communication, forms the theoretical rationale for the proto-syllabus proposed here. Constructivist learning, in which students and teachers co-create knowledge “assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understandings of the subjects’ meaning” (Charmaz, 2000, p. 510). This syllabus will need to acknowledge the social realities of the students: they need Spanish for work, they
do not have a lot of time or money, and they do not need to start at the beginning with a
general course. In terms of the mutual creation of knowledge, this will be a process
syllabus (Irujo, 2000) that will be filled in by the students as the course progresses.

Edmundson and Fitzpatrick (2000) revealed that it was clear in the case of health
care professionals that “if the learners participate actively in the decision-making process
this is likely to help inculcate an awareness of both individual and group wants and
needs, and learning strengths and weaknesses” (p. 164). This group awareness of its own
learning is essential for mature professionals who have specific and immediate language
needs and goals.

Martyn (2000) made a compelling argument for negotiated syllabuses when
language instruction was directed towards professional purposes that were not shared by
the language teacher. She pointed out the “need for graduates to meet professional
expectations in a field in which [she] was only able to enter based on the willingness of
nurses to share knowledge, processes, and needs” (p. 154). Participant input is essential
when the teacher and the students do not share an area of expertise, but both areas are
essential to successful outcomes. For this study, bridging the gap of professional
knowledge began at the needs analysis stage with the potential teacher participating in the
potential students’ professional context.

The results of the present study also suggest some practical considerations might
be important in preparing a language course for practicing professionals. Following the
discussion of the practical considerations is a proto-syllabus that could serve as a
framework for a medical Spanish course for practicing medical professionals.
Besides a basic pronunciation and grammar guide, as provided in many available texts, a lot of traditional beginner class materials could be eliminated. Learners will be anxious to be able to immediately use Spanish on the job and many will already be using rudimentary Spanish. Because it is difficult to say beforehand what specific information an individual student will need, it might be better for the instructor not to select specific texts, but rather provide a list of possible useful references and work with each individual to narrow the list of appropriate resources.

Issuing a survey at the start of the course could determine how long students have been in their profession, what Spanish they are already using on the job, and their previous experience with language study. A high level of comfort with professional responsibilities might allow professionals to focus more attention on on-the-job language study. Knowing what Spanish students are already able to use would allow the teacher to avoid redundancy while knowledge of students’ previous experience with language study can help determine learning styles and appropriate approaches to grammar instruction.

An increased focus on input instead of output would address the imbalance observed in this study between productive and receptive abilities. Rather than focusing on direct instruction in vocabulary for productive ends, students could be referred to resources to be synthesized into a format that will be useful at work. Class time could then be dedicated to listening comprehension.

In his study of teaching communicative functions in the workplace Koester (2000) concluded that “it is important to move away from simply teaching lists of phrases” (p. 179). Koester’s suggestion that “language awareness activities should play an important
role, which could involve (among other things) exposing learners to real-life recordings or transcripts” (p. 179) certainly applies to the group of learners who participated in this study. Though exposed to input and capable of producing output, the participants in this study lacked language awareness and listening abilities comparable to their speaking abilities. Koester recommended using naturally occurring conversations in the classroom either by playing tape recorded conversations for listening practice or by using “insights gained from naturally occurring talk…to devise classroom tasks” (p. 179) such as unjumbling tasks or using text of naturally occurring conversation in skeleton form for role playing activities.

A focus on strategy instruction for improving production and reception of spoken Spanish would provide students with the tools to “learn to learn” so that they could continue the process outside of class. Because language instruction must account for “individual variation present in strategy use” (Grenfell, 2000, 14) teachers should first try to assess student needs with regard to strategies and then offer instruction on as many strategies as possible. Thorogood (2000) suggested that an understanding of students’ strategic needs was important because “the range and scope of tasks to be accomplished may [be] so vast and so unpredictable as to require a comprehensive repertoire of language strategies, or so limited and so predictable as to need little more than a phrase-book repertoire with a few job-related manipulations and substitutions” (pp. 141-142). By offering various strategies learners can begin to reflect on their learning processes so that as they are offered more strategies, they can practice those strategies, automatize the successful ones, and reflect on the whole process (Grenfell, 2000, p. 16).
Bongiovanni (2000) made specific strategy suggestions for health care professionals. For example, she recommended using fill-in-the-blank yes/no questions to follow-up other yes/no questions. “On the basis of responses made previously by the patients, the interviewer can gain additional information simply by substituting the known information into the question” (p. 5). If a patient reported a cough, the attending health care professional could ask, “was the cough accompanied by [another symptom]?” Bongiovanni also stressed the importance of using gestures, emphasizing that “the interviewer must actively point to or demonstrate a particular item” (p. 6) whenever possible.

Samuels (1987) discussed important factors to consider when providing strategy instruction for listening comprehension. He divided the factors into two groups: inside-the-head and outside-the-head. From a constructivist point of view inside-the-head factors correspond to listening strategies and outside-the-head factors correspond to speaking strategies. According to Samuels, the inside-the-head factors that both teachers and students must consider in developing listening strategies include intelligence, language facility, background knowledge and schema, speech registers and awareness of contextual influences, metacognitive strategies, kinesics, and motivation (pp. 298-299). Listeners have to have the language facility to learn to automatically segment what they are hearing in order to understand the whole message instead of focusing attention on individual words in the message (p. 299). Alternatively, they could learn strategies that would engage the speaker in parsing the speech into comprehensible parts.
Samuels’ outside-the-head factors include discussion topic, speaker awareness of audience need, clarity and speaker effectiveness, and context (p. 298). Speakers must judge their interlocutor’s familiarity with the topic under discussion as well as the inside-the-head factors controlled by the interlocutor. Speakers must be organized and avoid presenting too much information at once, while asking their audience to do the same.

The above-mentioned survey could lend insight into the inside-the-head and outside-the-head factors that should be addressed from both the perspective of teaching the learners to be good speakers and listeners and teaching them to be aware of the same factors in their interlocutors.

5.4.1 Proto-syllabus for Spanish for Health Care Professionals

Spanish for Health Care Professionals is a course designed specifically for working professionals who want to learn Spanish for professional purposes. The focus will be almost exclusively on medical Spanish, as determined by the students in the weekly class meetings. Each class will address the previous week’s assignment and determine the focus for the following week. Through the course, students will:

- listen to the Spanish language from various sources (video tapes, audio tapes, guest speakers, the instructor, and classmates) as used in a medical context
- practice listening comprehension strategies to improve understanding of the spoken language
- learn about Spanish-speaking cultures, especially as it relates to medical settings
- gather and organize resources to improve Spanish speaking skills
• integrate the course with specific, individual workplace challenges related to communicating in the Spanish language.

Each week’s class will consist of the following:

• **Taped (audio and video) “patients.”** Students request topics and native speaker “patients” are recorded each week for in-class analysis the following week.

• **Work-related dialogues.** Starting with scripted dialogues taken from the taped “patients,” students working in pairs or groups will unjumble written dialogue, practice scripted dialogues, develop dialogues based on naturally occurring conversation in skeleton form, and engage in spontaneous dialogues about specific topics with other students and the teacher.

• **¿Qué hay de nuevo? (What’s new?):** Students provide topics from what they have heard throughout the workweek as they employ listening strategies—new things that they understood or things that they did not understand and want to decipher in class. New listening strategies will be discussed throughout the course, as well as their effectiveness on the job.

• **¿Qué es lo que digo? (What is it I’m saying?)** “I can say the words, but what am I really saying?” We discuss the grammar components of interest to students and try to find new contexts for their use.

• **Culture.** Guest speakers, videos, and readings present some of the cultural aspects involved in patient care when patients do not share the native culture of health care professionals.
• **Bilingual dialogue journals.** Students keep a record of their contributions to the “¿qué hay de nuevo?” and “¿qué es lo que digo?” portions of the course, including a weekly entry about their increased linguistic and cross-cultural consciousness in both Spanish and English and the teacher will respond in writing each week.

• **Final reflection paper.** A final paper of 5-10 type-written pages in which students reflect on the course—what they have learned, how their listening strategies have changed, what they liked about the course, and ways they would improve the course.

**Evaluation.** Evaluation for the course will be based on the following:

Participation in weekly in-class and workplace tasks: 50%

Bilingual dialogue journals: 25%

Final reflexive paper: 25%

**Required materials:** A binder or notebook in which to write the dialogue journal. It should take the form of something that can be continued through the week while the teacher has the previous week’s entries.

**Recommended texts.** The following texts are recommended for those who are seeking reference materials. There are no required texts for the course. Most texts are available at Barnes & Noble and Borders (or their respective online stores).


5.5 Recommendations for further research

In the present study, the researcher helped the participants develop productive skills and observed the need for receptive skills. Though listening skills were clearly needed by the participants in this study, further research would be required to determine the role of listening, to establish whether and how big a difference between receptive and productive abilities exists, and how to develop listening skills in a workplace context.

Patients were not included in the present study, but their input into this study would have been useful, especially with respect to issues of reciprocity and power dynamics. Patients’ insights might have helped determine how well the professionals’ output was received. The language learning of the patients would also be a valuable area for further study, examining the same issues that were examined for the health care professionals in this study.

Quantitative studies, such as pre-test post-test designs of a class of professionals taking Spanish, would lend further insight into questions that were addressed in this
study, such as what linguistic structures are acquired by health care professionals and how they are acquired. Further study of if and how regular and irregular linguistic structures are acquired in the natural setting of a workplace would be useful.

Research conducted during a Spanish course for working health care professionals might examine the role of instruction in learners’ forming an understanding of a second language system. The learners in this study had access to input and produced output, yet seemed unable to understand the Spanish linguistic system. All were lacking direct instruction and studies to explore the influence of direct instruction where input and output already exist would be interesting.

5.6 Reflections on the research process

Elements of the proto-syllabus presented above could be used as an instrument in a quantitative pre-test, post-test study conducted during a medical Spanish course. A listening test would be administered on the first day of class, the listening elements of the course would serve as the instrument, and the same listening test would be administered on the last day of class to determine if any significant differences resulted from the course. Student dialogue journals and final reflexion papers would also provide qualitative data on the changes in language skills during the course.

The fact that participation in this study required an enthusiasm for learning Spanish as well as a willingness to commit personal time to interviews limited the presence of disconfirming cases. Had other participants been included as disconfirming cases, the researcher might have found a greater need for basic pronunciation skills in
Spanish as well as the need for a vocabulary base relevant to their daily work, as possessed by those who participated in the study.

Though their insights may have been helpful to this study, patients were not included because of confidentiality issues in medical settings. Through interviews and documented conversations, patients might have lent a different perspective on the nature of communication in the clinic setting, particularly the challenges of communicating across language barriers. Interesting comparisons and contrasts could have been drawn between the patients’ and participants’ perceptions of the participants’ linguistic and cultural knowledge and needs. The patients’ ideas on issues of reciprocity and power would add a perspective that is not present in the current study.

When this research study began, it was primarily concerned with how to carve out the research space in which to work. I had to let go of that idea in order to get on with the study. The research had a greater influence on the researcher than the researcher had on the research. The researcher has to let the research go to work on her instead of planning how to work on the research.

In the process of conducting this study, the need for the researcher to balance the roles of insider and outsider was constant. Becoming too comfortable in the role of an interpreter participating in the workplace setting hurt data collection because observation slowed as participation increased. Focusing too much on data collection endangered the researcher’s comfortable place with the informants. It was a constant balancing act, struggling to “get the right stuff” in the fieldnotes. Each researcher might approach the same research environment from a different perspective and therefore focus on different
aspects of the environment. For example, as a foreign language educator this researcher focused on the English-speaking health care professionals’ Spanish language learning, but another researcher interested in English as a Second Language might have focused instead on the Spanish-speaking patients’ English language learning. Any setting, any human participants, are too complicated to presume that the data, analyses, and interpretations would be the same regardless of the identity of the researcher. While the premises of qualitative research acknowledge such complications, the same standards of quality research apply to any researcher in any setting.

Like MacLeod’s struggle to maintain his dual roles as director of an urban youth program and as ethnographer in the same urban community (1987), this project involved a struggle between the roles of volunteer interpreter and ethnographer. Like MacLeod, the concern that one role was having a negative impact on the ability to fulfill the other persisted throughout the study. It felt like a violation of Spindler’s (1982) criterion that “inquiry and observation must disturb as little as possible the process of interaction and communication in the setting being studied” (p. 7). The interpreter role clearly impacted the process of interaction and communication that would have occurred had the researcher not been there. Not to help communication would have been an ethical dilemma both from the humanitarian perspective of facilitating the provision of medical services and from the biographical perspective of a Spanish teacher who tells and shows her students that fundamentally we are learners of Spanish so that we can meet learners of English halfway and communicate with them. To not carry that idea outside the classroom would have a negative impact on the role of professional teacher. During this
study, while attempting “to achieve some workable balance between participating and observing” (Wolcott, 1995, p. 95), it became clear that the role of teacher was primary and that of researcher was secondary.

The power differential that was created because the researcher spoke Spanish and the health care professionals did not also posed a dilemma. In the first place, they had to have complete faith that their words were being communicated to the patients accurately. That gave tremendous power to the interpreter. On another level, the presence of someone fluent in Spanish in the clinic probably impacted the professionals’ use of the Spanish they knew. Either they felt no need to use it when a fluent speaker was there or were intimidated to use it in the presence of a fluent speaker. Awareness of this power differential is something feminist epistemologies have brought to qualitative research as they “have argued that the relationship between the researcher and her subjects is a social relationship, and is bound by the same patterns of power relations found in other social relationships” (Andersen, 1993, p. 51). The researcher could not separate herself from the participants in the research setting. She became a member of the setting, with all the relationship dynamics that implied, such as forming a friendship with some participants and experiencing tension in interactions with other members of the community.

These dilemmas can also benefit research by creating a space for “productive discomfort” (Herzfeld, 1996, p. 41). By constantly problematizing the researcher’s own situation she was able to continuously and repeatedly make the familiar strange so that her own discomfort might lead to productive results.
While writing the last two chapters, knowledge that participants would read them in the process of member checking emphasized the importance of triangulating data. It forced the researcher to be aware of the participants as participants in the whole process, not just subjects used solely for the benefit of research. Rather than impacting the content of what was written or the way in which the data were interpreted, the self-consciousness the researcher sometimes felt helped keep the focus on language, both in the sense of the language used in writing up this research and the study of language that was the focus of the research. For example, when a controversial issue related to reciprocity or power dynamics aroused concerns that it might be inappropriate or offensive, it was usually because the issue was too far afield of the focus on language.

As chapter four opened with participant portraits, chapter five will close with participant reflections. The member checks allowed participants to form a community of learners. They worked in isolation, but when they read about each other, they realized that they shared similar experiences. As Beth said, “It was kind of neat to see what was written about everybody else, too, because it made me not feel so stupid” (interview 3, 112-113). She said, “It was interesting to hear other people do the same things that I’ve done” (215-216). About reading chapters four and five, Kim said, “I think it helps to read it, too, because then you know that…if that’s how they’re learning then it’s good that I’m learning the same way, too” (interview 3, lines 115-117). Bernice said she enjoyed “reading what everybody else does because you don’t know if you do something that nobody else does. And I also like reading what they did because then I think, ‘I wonder if I highlight pamphlets and then point to the really important part?’” (interview
3, 66-70). She added, “reading this has made me think we all manage different ways. We find ways to make it work out” (182-183). Kim noticed that she used a lot of the same strategies as others without realizing it. After reading about Nancy and Bernice’s communicative strategies, Kim found herself saying, “I do that…I do it all the time” (interview 3, 101-105).

In her third interview, Beth said that the study helped her to realize “there is just so much” (156). She was discouraged, because she wanted to become bilingual someday, but did not see it as a possibility after the study. Nancy seemed to understand that learning Spanish was an ongoing process. About periods of time during which she had stopped, taken a break, had not made progress, or had forgotten Spanish she once knew, she said “I feel like I have some ways that I can pick up and when I’m motivated, keep at it” (interview 3, 96-98). She did not get discouraged: “I don’t try to…give myself too hard of a time over that because I just feel like learning can be ongoing and…if I’ve plateaued or focused on some other things it just doesn’t mean that I can’t do it again” (interview 3, 293-296).

While it would be a mistake to discourage people from pursuing bilingualism, understanding what is involved in becoming bilingual is too often absent from language education. By providing tools to get through communicative exchanges, communicative language teaching makes it possible to help students develop communicative competence and use language to communicate without the expectation of necessarily becoming fluent. Within such a realistic framework, students can achieve a great sense of accomplishment
without becoming discouraged by a lack of fluent bilingualism. Additionally, it might foster greater sympathy for English-language learners.

Kim noticed that it took a long time to recognize that prepared scripts would be most helpful to the participants, yet it was an easy need to fill once it was discovered. In reference to the simple scripts that ultimately proved to be the most helpful tool for the participants, Kim commented, “look how simple…look how much help you did in such a short little time. If I would have known that that’s exactly what you could have been doing, then I would have said, ‘well, this is what I need.’” She also ascertained that a key factor was the researcher’s presence in the workplace: “in a class if that teacher could go into the person’s…situation or whatever” (interview 3, 347-356).

The participants also enjoyed seeing the final product that resulted from their interviews and the researcher’s notebooks full of fieldnotes. In her member check interview, Beth commented, “I did think…when I was reading that, ‘oh my God, how much work that had to be’” (interview 3, 185-186). The researcher apologized for asking her to read such a lengthy text and Beth responded, “I thought it was very interesting…I was fascinated by it” (interview 3, 212-215). Nancy said, “I think it’s amazing what you have…put together and gleaned out of…us here. I’m sure that it probably took a lot of time to just…pick out the bits and pieces of what you saw with all your background research and…figure out…how to put it all together (Nancy, interview 3, 367-373). Bernice said, “I liked seeing all of what came out of it and how you analyzed it…I liked things that you looked at and analyzed that I might not have thought about [and] just looking at all what you got out of it” (interview 3, 288-295). Needless to say, the
researcher was pleased to have such enthusiastic participants and grateful at their willingness to give up their personal time to participate in the interviews and read the first draft of chapters four and five.
APPENDIX A

Interview schedule

Interview 1

Pseudonym:

I will ask this again at the end of the interview, but before we begin, do you have any questions for me?

Could you describe your work? (or a typical day at your work)

How long have you been working in this field? Please describe your career.

How long have you been working at this job?

How did you come to this work? (or to work here)

What Spanish do you use on a daily basis at work? Can you say the typical words and phrases you use? We can role play if that would help.

How would you characterize your Spanish language proficiency?

How does what happens in your office differ with Spanish-speaking and English-speaking clients?

What do you use to help you communicate with Spanish-speaking clients?

What do you need to better communicate with Spanish-speaking clients?

What cultural differences do you know about? What cultural differences would you like to know more about?

Is there anything else you think I should ask about this?

Do you have any questions for me?
Interview 2

Before we begin, do you have any questions for me?

Since we last spoke, have you thought more about your use of Spanish in the work place?

Have you learned any new words or phrases?

Have you tried any new strategies to help you communicate with Spanish-speaking clients? If so, how have they worked?

Have you noticed any differences in what happens in your office with Spanish-speaking and English-speaking clients?

Have you thought of anything you use to help you communicate with Spanish-speaking clients?

What do you think you still need to help you better communicate with Spanish-speaking clients?

Is there anything else you think I should ask?

Do you have any questions for me?

Interview 3

Before we begin, do you have any questions for me?

Today I would like to look back on our first two interviews. In the first interview, you said you thought you needed _____________ to help you better communicate with Spanish-speaking clients.

Is that still true?
Do you think you’ve made any progress in your ability to communicate with Spanish-speaking clients?

Last time we talked you said you were working on ______________ to improve communication.

Are you still doing that?

Is it working?

Have you tried anything new?

What do you think is a realistic solution to the communication problems you encounter at work?

What do you think are realistic goals for you to achieve individually to improve communication with Spanish-speaking clients?

As you know, I am interested in developing Spanish classes for working professionals. What would you look for in a Spanish class?

You have named the following things:____________________ (show interviewee a written list) Can we prioritize these from most important to least important

Is there anything else you think I should ask?

Do you have any questions for me?
APPENDIX B

Second Language Acquisition in the Health Care Profession

Date

Greetings Name,

I am a graduate student in Foreign and Second Language Education at the Ohio State University and I am conducting a study on second language acquisition in the professions. Specifically, I will examine the language needs of health care professionals. Starting with observations of the communication that takes place between English-speaking health care professionals and their Spanish-speaking clients I hope to discover unique aspects of language acquisition for adult professionals who demonstrate a desire to learn Spanish. Based on the observations, interview questions will be designed to gain insight into the language proficiency and language needs of health care professionals from their own perspectives. The purpose of the study is to examine the ways in which further research might help language programs to better accommodate the linguistic needs of health care professionals and result in this target group having its language needs met.

If you agree to participate in the study, your involvement will take no more than three hours of your time. You will be asked to tape record three interviews with me. Interviews will be recorded only with your consent. There are no foreseeable risks from your participation, because this is a descriptive study.

Your participation is completely voluntary and you will be free to refuse or stop at any time without penalty.

Please feel free to contact me any time with questions, concerns and/or suggestions.

Sincerely,

Darcy Lear
Co-investigator
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Columbus, Ohio 43214
614-262-8065
lear.18@osu.edu
Dr. Charles R. Hancock
Professor
College of Education, School of Teaching and Learning
Principal Investigator
e-mail: hancock.2@osu.edu
phone: 292-8047
APPENDIX C

Consent for participation in research: Interview data

I consent to participate in research entitled: Communicative needs of English-speaking health care professionals who work with Spanish-speaking clients: A case study.

I understand I will be interviewed by Darcy Lear (co-investigator) on my experiences with using the Spanish language in the workplace. I understand the interviews will be audio taped and will take approximately one hour. I give my informed consent to the researchers to use my interview data for this research.

I understand that audio recordings of the interviews will be reviewed only by the researchers in charge of the study and that my confidentiality will be protected. I understand the researchers will use a pseudonym for me (no last name will be used) when writing the results of this research. This will serve to protect the confidentiality of my responses. After this dissertation has been completed and defended and articles arising from this research have been published, the interview audio tapes will be destroyed.

Dr. Charles R. Hancock, Principal Investigator, or his authorized representative, Darcy Lear, Co-Investigator, has explained the purpose of the study, the procedures to be followed, and the expected duration of my participation. Possible benefits of the study have been described, as have alternative procedures, if such procedures are applicable and available.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction. Furthermore, I understand that I am free to withdraw consent at any time and to discontinue participation in the study without prejudice to me.

Finally, I acknowledge that I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Signature____________________________________  Date___________________
Investigator___________________________________ Date___________________

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Please contact the researchers at any time if you have any questions or concerns about this research.

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The Ohio State University
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phone: 292-8047
APPENDIX D

Demographics of perinatal clinic staff

<table>
<thead>
<tr>
<th>Participant code letter(s)</th>
<th>Job title</th>
<th>Sex</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Medical doctor</td>
<td>M</td>
<td>W</td>
</tr>
<tr>
<td>J</td>
<td>Midwife</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>N</td>
<td>Midwife</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>Y</td>
<td>Midwife</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>SM</td>
<td>Student midwife</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>B</td>
<td>Charge nurse</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>P</td>
<td>Charge nurse</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>G</td>
<td>Charge nurse</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>BB</td>
<td>Nurse</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>JJ</td>
<td>Nurse</td>
<td>F</td>
<td>B</td>
</tr>
<tr>
<td>CC</td>
<td>Social worker</td>
<td>F</td>
<td>B</td>
</tr>
<tr>
<td>A</td>
<td>Social worker</td>
<td>F</td>
<td>B</td>
</tr>
<tr>
<td>K</td>
<td>Nutritionist</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>D</td>
<td>Nurse's assistant</td>
<td>F</td>
<td>B</td>
</tr>
<tr>
<td>DD</td>
<td>Nurse's assistant</td>
<td>F</td>
<td>W</td>
</tr>
<tr>
<td>JU</td>
<td>Nurse's assistant</td>
<td>F</td>
<td>B</td>
</tr>
<tr>
<td>AA</td>
<td>Community outreach</td>
<td>F</td>
<td>L</td>
</tr>
<tr>
<td>M</td>
<td>Community outreach</td>
<td>F</td>
<td>L</td>
</tr>
</tbody>
</table>

Racial descriptors: B=black, W=white, L=latino

The order of the list is more or less hierarchical by job title, education and authority within the clinic setting. Some roles require more education (social worker, nutritionist) than job titles listed higher in the table, but are more peripheral to the majority of clinic activity. The only male is the medical doctor, who is highest in the hierarchy regardless of the frequency of his presence in the clinic environment. The two
community outreach employees, the only Spanish-English bilinguals on the staff, act almost entirely as interpreters in the clinic environment and have little time to actually go into the community.
APPENDIX E

Document analysis, pilot study

Three of the four documents examined here have been created and used by health care professionals at the Bryden House perinatal clinic on the east-side of Columbus, Ohio. All three have been handwritten either on scrap paper or a Post-it note, designed specifically for short notes, labels or reminders. In each case, the person created the document in order to meet her own specific perceived need. The prominence and permanence of such scraps of paper, seized in a time of opportunity or need, is illustrated in the fact that two of these notes are adhered to the walls of the clinic.

The social worker has a three-inch by three-inch light pink Post-it note taped to her wall along with informational flyers related to her work and inspirational sayings. It reads:

Me llamo _________  (My name is _________)
Yo soy  (I am a)
Trabajadora  (worker)
Social  (social)

Her printed script uses a mixture of capital and lower case letters (the letter ‘a’ at the end of a word seems to get capitalized). In the case of the single word “trabajadora” (worker), she has clearly separated it into two words. The text has been memorized as a
series of discrete lexical units, but without any sense of their grammatical meaning beyond a rough translation. The first time I noticed the Post-it note was when she mixing what she has noted as two separate lexical units (“trabaja” and “dora”), but which really are only one (“trabajadora”).

Outside the social worker’s office, tucked into a corner directly inside the door that separates the waiting room from the offices, stands the clinic scale. Taped to the wall at eye level is a square of white paper that looks like one-quarter of an eight-and-a-half by eleven sheet of paper that has been ripped to use as scrap paper. It reads:

VOLTEARSE

Or

GIRARSE

Both words mean “to turn around.” They are in their infinitive form so to say them without conjugating them roughly translates to “to turn around” as opposed to the more desirable command form, “turn around.” Presumably, these words are used when a nurse wants the patient to turn around to be measured, but I have never heard it used. Height is only measured at patients’ first visit, called “intake.” The note is the only thing on a bare, shadowed wall. It easily escapes notice and seems as if it has been forgotten by all most of the time.

After doing a first-time pelvic exam on a Spanish-speaking patient without an interpreter, a distraught student midwife approached me with an eight-and-a-half by eleven piece of pink paper, folded in half to eight-and-a-half by five-and-a-half and asked
for help in getting down some basic, necessary vocabulary. The construction of the
document consisted entirely of her asking “how do you say…?” I did not provide any
input beyond translating the requested terms and, in one case, offering what I thought was
an easy figurative translation in addition to a literal, yet still somewhat awkward,
translation. Spaced out fairly evenly, she wrote in neat print:

<table>
<thead>
<tr>
<th>Hispanic</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>presión</td>
<td>(pressure)</td>
</tr>
<tr>
<td>bien</td>
<td>(good)</td>
</tr>
<tr>
<td>Ya está</td>
<td>(done, figuratively)</td>
</tr>
<tr>
<td>(terminado)</td>
<td>(done, literally)</td>
</tr>
<tr>
<td>relaje</td>
<td>(relax)</td>
</tr>
</tbody>
</table>

After what she felt had been a disastrous exam, due largely to an inability to
communicate, she seemed confident that these basic words would have helped. One
week later when I asked her if she had the pink sheet so that I could make a copy in order
to do a document analysis she said she did not have it, but went to get something else to
show me. It was a twenty-page bilingual obstetrical database printed from the Ohio State
University Medical Center web page (attached). The list serves as a “best of” dictionary
for anyone dealing with obstetrics patients. It is neatly categorized with extensive lists of
essential vocabulary—much less cumbersome than a bilingual dictionary, with all of its
superfluous vocabulary. While a useful and valuable document or study tool before or
after an exam (or any other client interaction), the exhaustive nature of the list would be a
deficit in the middle of an exam in which the midwife wanted to use only one of the
hundreds of words listed. The accessibility and efficiency of the small, handwritten documents analyzed above is lost in this neatly typed, official-looking document.
APPENDIX F

Communication in the clinic setting, pilot study

Codes: COM+ an episode of successful communication
      (COM-) a breakdown within an episode of successful communication
      NO unsuccessful communication
      COM- an episode of communication that requires an interpreter
      (COM+) successful communication without interpreter while the interpreter
      is present to otherwise facilitate communication

This graphic reveals that communication is far more complex than one might imagine,
even in a setting where the topics are limited, the exchanges redundant, and the discourse
level limited by a language barrier. At first, the data seemed to reveal three kinds of
communication between the English-speaking staff and the Spanish-speaking clients in
the clinic: successful communication, successful communication only through the
facilitation of an interpreter, and unsuccessful communication. However, closer
examination of the data reveals many examples of successful communication being interrupted by a breakdown in communication that either goes unresolved or is resolved through the intervention of the interpreter. Likewise, aided communication often enjoys a “reverse breakdown” in which the English-speaking staff member and the Spanish-speaking patient communicate without the intervention of the interpreter. These subtleties may have the potential to lend insight into how to improve communication, especially if patterns in the breakdowns and “reverse breakdowns” can be identified and used as starting points toward more consistent successful communication.
APPENDIX G

Barometer of cultural sensitivity in a perinatal clinic, pilot study

<table>
<thead>
<tr>
<th>High</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
<td></td>
</tr>
<tr>
<td>Food availability</td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Health issues</td>
<td></td>
</tr>
<tr>
<td>Breast feeding</td>
<td></td>
</tr>
<tr>
<td>STDs</td>
<td></td>
</tr>
<tr>
<td>Birth control</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low</th>
<th></th>
</tr>
</thead>
</table>

This scale is meant to illustrate only the issues that appear in it as they relate to each other. Certainly there are other cultural issues to be explored and the ones that do appear can and should be researched in greater detail. Data show a high sensitivity among clinic staff to poverty, perhaps because all clients, regardless of culture, have that in common at the public clinic that charges clients on a sliding scale based on income. There is a related sensitivity to the possibility that poverty may preclude the purchase of certain healthy foods such as fresh fruits and vegetables and lean meats. There is less
sensitivity to cultural practices related to food. Beyond the observation that Latina clients prefer dried beans over peanut butter when selecting a protein for the Women, Infants & Children program, nutritional counseling is the same for all clients, regardless of culture (with mainstream U.S. culture serving as the norm).

Health issues enjoy the least cultural sensitivity. This could be related to a wider trend in the U.S. in which health care professionals provide care according to a "one right way" model, widely disregarding patients' cultural practices and patients as individuals when doling out medical services. Within health issues, there is more cultural awareness of Latino practices regarding breastfeeding, but like the "beans over peanut butter" generalization, breastfeeding practices have been generalized to "they throw out colostrum and wait for breast milk to 'come in,' not realizing that the baby suckling is what makes milk come in." The subject of STDs is treated the same for all clients with little attempt to ascertain the clients' understanding of the issue. Family planning and birth control appears to be the most blatantly insensitive cultural issue as interpreters are frequently asked to translate the straightforward question, "what type of birth control will you be using after the baby is born?" The question is never phrased in such a way that not using birth control is an option, nor are the birth control options discussed in a way that is sensitive to those who may be unfamiliar with reproductive knowledge, birth control, and birth control methods.
APPENDIX H

Work-up interview script

The following initial interview items have been compiled from the interviews and observation notes. In their actual use there is some variation depending on who is speaking and how well they control the language. The starred items are only asked to patients who are more advanced in their pregnancies.

¿Fue al baño?
Did you go to the bathroom?
¿Nos ha dado una muestra de orina hoy?
Have you given us a urine specimen today?
Su peso, por favor.
Your weight please.
  Quitese los zapatos.
  Take off your shoes.
Suba otra vez.
Get back on the scale.
# libras más.
# more pounds.
Voy a tomar la presión de la sangre.
I am going to take your blood pressure.
¿Dolores de cabeza?
Headaches?
¿Vómitos?
Vomiting?
¿Vista borrosa?
Visual disturbances?
¿Nauseas?
Nausea?
¿Hinchazón en las manos o los pies?
Swelling in the hands or feet?
¿Flujo vaginal?
Vaginal discharge?
  ¿Es normal?
  Is it normal?
  ¿Comezón?
  Does it itch?
  ¿Olor?
  Does it have an odor?
  ¿De qué color?
  What color is it?
¿Dolor?
Pain?
*¿Contracciones? / ¿Cólicos?
Constructions?
  ¿Todos los días?
  Everyday?
  ¿Cuántas veces en una semana/en un día?
  How many times a week/a day?
¿Estás tomando las vitaminas?
Are you taking the vitamins?
¿Necesita más vitaminas?
Do you need more vitamins?
*¿Se mueve el bebé?
Is the baby moving?
¿Necesita cupones de WIC?
Do you need WIC coupons?
¿Preguntas o problemas?
Any problems or questions?
¿Todo bien?
Everything is okay?
APPENDIX I

Postpartum interview script

¿Cómo se llama el bebé?  What’s the baby’s name?
¿Cuánto pesó el bebé al nacer?  How much did the baby weigh at birth?
¿El bebé recibió cuidado especial en el hospital?  Did baby get special care at the hospital?
¿Ud. y el bebé salieron del hospital juntos?  Did you and baby leave together?
¿Le da de pecho, biberones, o los dos?  Breastfeed, bottles, or both?
¿El parto fue espontáneo o provocado?  Spontaneous or induced?
¿Le dieron medicina por el suero para aumentar las contracciones?  Pitocin?
¿Tuvo un parto vaginal o cesáreo?  Vaginal or C-section?
¿Problemas con el parto?  Problems with the delivery?
¿Le dieron medicinas al salir del hospital?  Did they give you medicines at discharge?
¿Cuáles?  Which ones?
¿Le dieron inyecciones en el hospital?  Did you get any immunizations?
¿Le duelen los senos? ¿Tiene bolitos?  Do your breast hurt? Any lumps?
¿Le cortaron?  Episiotomy?
¿Tiene puntadas?  Do you have stitches?
¿Le sanó?  Is it healing?
¿Está sagrando?  Are you bleeding now?
¿Ha tenido una regla?  
Have you had a period?

¿Tiene estreñimiento? ¿diarrea?  
Do you have constipation? Diarrhea?

¿Tiene dolor o ardor cuando orina?  
Does it hurt or burn when you urinate?

¿Está triste? ¿Está deprimida?  
Are you sad? Are you depressed?

¿Cuál método anticonceptivo piensa usar?  
What birth control method do you plan to use?

¿Ha tenido relaciones desde que nació el bebé?  
Have you had sex since delivery?

¿Usó un método anticonceptivo?  
Did you use contraception?

¿Tiene una clínica para el bebé? ¿Dónde?  
Do you have a clinic for baby? Where?
APPENDIX J

Women, Infant and Children nutrition program script

¿Ha tenido WIC antes? Have you had WIC before?

WHAT IS WIC?

WIC es un programa de nutrición para mujeres, bebés y niños menores de cinco años. Recibes información sobre nutrición y cupones para comida gratis.

WHAT YOU NEED TO BRING:

Usted necesita una identificación con su fecha de nacimiento y un talón de cheque del último mes.

IDENTIFICATION CARD

Primero, necesitas la identificación para el programa. Firma aquí. Escribe los nombres de hasta dos otros adultos que pueden usar sus cupones. Por ejemplo, tu esposo, tu hermana. Necesitas la identificación para usar los cupones en el supermercado.

FOOD ITEMS

Estas [és-tas] son las comidas que puedes recibir con los cupones:
Un total de 36 onzas de cereal; puede ser una caja [ká-ha] de 36 onzas; o 3 cajas [ká-has] de 12 onzas cada una; o una caja de 24 onzas y otra de 12 onzas.
Frijoles o mantequilla de maní
Un gallón de leche
Una docena de huevos
Queso
Jugo líquido o helado

SUPER MARKETS

Los supermercados que aceptan los cupones son Meijer, Kroger, y Big Bear. Aquí hay una lista.
HOW THE COUPONS WORK

Hay cuatro cupones por mes, es más o menos un cupón por semana. Tienes que usar los cupones entre esta fecha (first date) y esta fecha (second date).

Con cada cupón se puede comprar las comidas que están en el cupón: (examples)
APPENDIX K

Reception strategies in interactive listening

Más despacio, por favor.  
Slower, please.

¿Mande? / ¿Cómo?  
What? Pardon me?

Por favor, ¿puede repetirlo?  
Can you please repeat that?

¿Qué significa ________?  
What does _____ mean?

¿Me lo puede explicar de otra manera?  
Can you explain it another way?

¿Cuál fue la última palabra?  
What was the last word?

¿Me puede dar un ejemplo?  
Can you give me an example?
APPENDIX L

Grammar explanation

EL PASADO: imperfecto y pretérito

USOS DEL PRETERITO E IMPERFECTO

• PRETERITO:
  • acción que ya terminó
  • el principio o el final de una acción

• IMPERFECTO:
  • descripciones
  • condición física, emocional, mental
  • la hora, la edad, el tiempo
  • repetición (“used to do”, “would do”)
  • “was/were doing...”

EL IMPERFECTO (del indicativo)

<table>
<thead>
<tr>
<th>-AR</th>
<th>-ER, -IR</th>
</tr>
</thead>
<tbody>
<tr>
<td>-aba</td>
<td>-ábamos</td>
</tr>
<tr>
<td>abasar</td>
<td>-abais</td>
</tr>
<tr>
<td>aban</td>
<td>-aban</td>
</tr>
</tbody>
</table>

LOS IRREGULARES:

SER: era, eras, era, éramos, eran
IR: iba, ibas, iba, íbamos, iban
VER: veía, veías, veía, veíamos, veían
EL PRETERITO (del indicativo)

-AR
-é -amos
-aste -asteis
-ó -aron

-ER, -IR
-í -imos
-iste -isteis
-ió -ieron

CAMBIOS EN LA PRIMERA PERSONA SINGULAR (“YO”):

• -GAR: g >> gu
  • llegar: llegué, llegaste, llegó, llegamos, llegaron
  • jugar: jugué, jugaste, jugó...
  • pagar: pagué, pagaste, pagó...
  • entregar: entregué, entregaste, entregó...

• -CAR: c >> qu
  • tocar: toqué, tocaste, tocó, tocamos, tocaron
  • buscar: busqué, buscaste, buscó, buscamos...
  • sacar: saqué, sacaste, sacó...

• -ZAR: z >> c
  • almorzar: almorcé, almorzaste, almorzó...
  • empezar: empecé, empezaste, empezó...
  • comenzar: comencé, comenzaste, comenzó...
  • adelgazar: adelgacé, adelgazaste, adelgazó...

CAMBIOS DE RAIZ EN LOS VERBOS -IR, TERCERA PERSONA SINGULAR Y PLURAL (él,ella,Ud.; ellos,ellas,Uds.)

• o >> u
  dormir: dormí dormimos
  dormiste dormisteis
  durmió durmieron

  morir: morí morimos
  moriste moristeis
  murió murió

• e >> i
  servir: serví servimos
  serviste servisteis
  sirvió sirvieron

  sugerir: sugerí sugerimos
  sugeriste sugeristeis
  sugirió sugirieron
mentir: mintió mintieron
repetir: repitió repitieron
preferir: prefirió prefirieron
reír: rió rieron
seguir: siguió siguieron
pedir: pidió pidieron
despedir(se): (se) despidió (se) despidieron
sentir(se): (se) sintió (se) sintieron
divertirse: se divirtió se divirtieron

"LA REGLA DE TRES VOCALES"

• i >> y entre dos vocales en verbos que terminan en -eer o -ruir

• leer: leí, leíste, leyó, leímos, leyeron
• creer: creí, creíste, creyó, creímos, creyeron
• construir: construí, construíste, construyó, construímos, construyeron
• destruir: destruí, dstruíste, destruyó, destruímos, destruyeron

• IRREGULARES

• ir: fui, fuiste, fue, fuimos, fueron
• ser: fui, fuiste, fue, fuimos, fueron
• dar: di, diste, dio, dimos, dieron

• cambio de vocal:
• hacer: hice, hiciste, hizo, hicimos, hicieron
• venir: vine, viniste, vino, vinimos, vinieron
• poder: pude, pudiste, pudo, pudimos, pudieron
• haber: hubo

• cambio de consonante:
• traer: traje, trajiste, trajo, trajimos, trajeron
• traducir: traduje, tradujiste, tradujo, tradujimos, tradujeron
• cambio de vocal y consonante:
  • querer: quise, quisiste, quiso, quisimos, quisieron
  • decir: dije, dijiste, dijo, dijimos, dijeron
  • estar: estuve, estuviste, estuvo, estuvimos, estuvieron
  • poner: puse, pusiste, puso, pusimos, pusieron
  • saber: supe, supiste, supo, supimos, supieron
  • tener: tuve, tuviste, tuvo, tuvimos, tuvieron
  • andar: anduve, anduviste, anduvo, anduvimos, anduvieron
LIST OF REFERENCES


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