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ORIGINAL ARTICLE

Language Barriers Surrounding Medication Use among Older Latinos

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Abstract Limited English language proficiency forms a significant challenge for many Latinos in clinical settings. Although medications are commonly used by older individuals as a means of maintaining good health and managing health problems, the extent to which English proficiency is related to medication use among older Latinos is not known. Focus groups were conducted with Latino, community-residing individuals aged 50 and over in eastern Massachusetts. Qualitative evaluation of the group interviews suggests that language is a barrier in dealing with medication for these individuals. Limited English proficiency appears to be related to feelings of being discriminated against in clinical and pharmacy settings. As well, communicating directly with health professionals in a common language is associated with level of trust and confidence in medical settings. Use of formal and informal interpreters, as well as seeking Spanish-speaking physicians and pharmacies with Spanish-speaking staff, are identified as strategies for overcoming health-related obstacles surrounding language.

Keywords English language proficiency · Patient–provider communication · Trust

Introduction

The growing diversity of the older population has prompted new concerns about health disparities and differential access to health care among racial and ethnic groups. One group

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of particular significance in this regard is Latinos. Recent projections indicate that the share of the 65 and over US population that is Hispanic will grow rapidly in coming years. By the year 2030, growth trajectories will result in Hispanics being second in size only to non-Hispanic Whites within the older population (US Bureau of the Census, 2004). As a result, it is important that we develop an understanding of the process underlying health-related decisions and behaviors of older Latinos.

An important vehicle by which good health in later life may be maintained, and health problems may be corrected or managed, is the appropriate use of medications. Older people take a disproportionate share of all prescription medications (Fillenbaum *et al.*, 1993), and polypharmacy (use of multiple drugs) occurs frequently (Haug & Ory, 1987). Due to the linguistic and literacy characteristics of the older Latino population, analysts frequently suggest that poor English language skills among many older Latino health care recipients—coupled with poor or no Spanish language skills among most health care providers—result in inadequate health care for older Latinos (Clark, Sleath, & Rubin, 2004; Lee, Batal, Maselli, & Kutner, 2002; Ortiz & Fitten, 2000). The implications for medication use of these potential linguistic barriers are virtually unknown.

The primary goal of this research project was to explore the factors shaping medication practices among older Latinos. In conducting this research, we discovered that language and communication issues challenge older Latinos' efforts to obtain and use medications. Strategies reported by our informants for overcoming these challenges, uncovered during the data collection phase of the study, are discussed later in the paper.

Literature Review

Although older Latinos experience somewhat lower rates of death than their non-Latino counterparts, most evidence points to a poorer health profile among the Latino elderly population than among other groups (e.g., Markides, Rudkin, Angel, & Espino, 1997; Stump, Clark, Johnson, & Wolinsky, 1997). Health deficits in the Latino population are traced in the literature to a combination of factors, including sociodemographic characteristics such as education level or insurance coverage, and contextual influences such as context and quality of care received (Smedley, Stith, & Nelson, 2003). Special emphasis has been placed in the literature on the significance of language barriers in shaping access to care and health outcomes. A substantial share of the older Latino population faces difficulty in communicating verbally in English (Bacigalupe & Gorlier, 2000; Mutchler & Brallier, 1999), and many are not literate in English (Mutchler & Bruner-Canhoto, 2000).

Linguistic barriers between patients and providers have been identified as representing an especially important challenge to the delivery of adequate care to many older Latinos. Language barriers in the clinical encounter may form an obstacle to effective patient–physician communication (David & Rhee, 1998; Smedley *et al.*, 2003; Weitzman, Chang, & Reynoso, 2004) and are linked to poorer doctor–patient relationships (Ferguson & Candib, 2002) as well as poorer patient satisfaction (Carrasquillo, Orva, Brennan, & Burstin, 1999; David & Rhee, 1998; Smedley *et al.*, 2003). Difficulty communicating also serves as a barrier to managing illness and accessing health care (Flores, 2000; Flores, Abreau, Olivar, & Kastner, 1998; Ponce, Hays, & Cunningham, 2005); for example, patients with limited English proficiency have been found to have fewer physician visits (Derose & Baker, 2000; Fiscella, Franks, Doescher, & Saver, 2002), longer hospital stays (John-Baptiste *et al.*, 2004), poorer understanding of chronic disease and self-care (Becker,

Beyene, Newsom, & Rodgers, 1998), and poorer adherence to treatment protocols (Smedley *et al.*, 2003).

In contrast to the large number of studies focusing on language barriers in the medical encounter, few studies have examined medication practices associated with language use among older Latinos. Older Latinos use both prescription and over the counter (OTC) medications somewhat less frequently than the older population at large, despite their poorer health profile (Espino *et al.*, 1998; Krauss, Machlin, & Kass, 1999). Yet older Latinos may be at high risk for complications and reactions associated with use of medications, due in part to language barriers and literacy deficits (Espino *et al.*, 1998). For example, individuals with limited English skills are more likely to report that the side effects of prescribed medications had not been explained to them (David & Rhee, 1998). Thus language barriers between patient and provider result in poorer understanding of treatments, and poorer patient adherence to medication regimes.

An additional factor underlying the ways in which communication barriers shape health care and medication practices is the use of informal networks in health care settings and decision-making. Family networks are linked to health behavior in later life, particularly so among older members of minority groups (Bagley, Angel, Dilworth-Anderson, Liu, & Schinke, 1995; Flack *et al.*, 1995; Johnson *et al.*, 1995). Family members are frequent participants in medical encounters (Prohaska, 1998) and may be active in medical decision-making (Dill, Brown, Ciambrone, & Rakowski, 1995). Among non-English speaking elders, bilingual family members and friends are recognized as intermediaries between health care providers and their patients. However, some concerns have been expressed about the extent to which informal interpreters such as family members provide accurate reporting (Flores *et al.*, 2003; Smedley *et al.*, 2003). Informal interpreters may provide incomplete or incorrect information, or may filter information in such a way as to restrict full participation of the patient in decision-making.

Summary

Older Latinos have a poorer health profile than do non-Latino Whites, and experiences with medications may contribute to this health disparity. Although little information on medication practices of older Latinos is available, some evidence suggests that this group's practices and experiences diverge from those of the larger population. Experiences obtaining and using medications, similar to experiences in the medical encounter more generally, may be shaped in part by communication barriers commonly occurring between Latinos and health care professionals. The purpose of this study is to explore the ways in which language barriers shape experiences obtaining and using medications, and to learn about the strategies undertaken by older Latinos to overcome these barriers.

Materials and Methods

To address the gaps in the literature surrounding medication use among older Latinos, we sought to explore the meanings older Latinos bring to medication use and to define preliminary questions for further research. Inasmuch as the information on factors associated with medication use among older Latinos is limited, with little theoretical guidance surrounding the role played by language in this process, we chose to conduct focus groups with a small number of target individuals (N=36).

The entire study, including consent forms and interview protocols, was approved by the IRB at our home institution before the recruitment stage. Our research team was interdisciplinary and included expertise in qualitative methodologies. At the outset, we formed an advisory group to provide feedback on each stage of the research process. The advisory group was composed of a social pharmacist holding advanced degrees in both sociology and pharmacy, with a research background in diversity in medication practices; a Latino researcher specializing in health issues within the older Latino population; and a methodologist specializing in the study of health and health outcomes. These individuals provided valuable advice regarding recruitment of subjects, data collection and analysis, including triangulation strategies.

To enhance the transferability of the results, a theoretical sampling frame oriented the configuration of the focus group participants' composition. In consultation with our research institutes, a number of study sites were identified. Within each location—community organizations serving elders and Latinos in eastern Massachusetts—study participants were recruited. To be eligible for participation in the study, individuals were required to be of Latino origin, 50 years of age or older, and a resident of eastern Massachusetts. Although recent immigrants to the area were not excluded (and, in fact, they were specifically recruited for one focus group), persons who were classified as *visitors* to the US were not included. Only community-residing individuals were selected as participants. Our targeted study locations were diverse in terms of characteristics of the Latino residents (including national origin, immigration patterns, and other demographic characteristics). This heterogeneity served the purpose of widening the discursive threads that were explored in the study and was also reflective of the composition of the interview groups. Four focus groups of 60–90 min were conducted between November 2001 and June 2002. The four groups included the following:

- Diabetics participating in a program for Latino patients (mixed gender)
- Attendees at a senior center (mixed gender)
- Recent (within 5 years) female immigrants at a community center
- Men at a community center

Focus group sessions were conducted in community facilities easily accessible to participants. Each participant received $30 in appreciation of his/her participation. The focus groups were conducted by one of the co-investigators, who is fluent in both Spanish and English. We found that although many of our participants reported that they spoke English well, all of them preferred to be interviewed in Spanish.

Prior to the first focus group, a focus group protocol, or list of topics to be covered in the focus group sessions, was developed by the investigators and refined in consultation with our advisory group. It was revised somewhat for each subsequent group based on what was learned in the previous interview (see Fig. 1 for complete focus group guide). The focus group discussions were preceded by a short self-administered questionnaire in order to collect basic demographic information about the participants. The questionnaire was translated to Spanish by two of the investigators whose first language is Spanish; participants were helped by interviewers to fill it out. Data collected through this questionnaire is included in Table I.

Description of the participants

As part of our study design, special efforts were made to include men among the participants, given known differences in health care behaviors between men and women

Topics

- *Experiences with medicines*
- *Over the counter and prescription medicines—differences in strategies*
- *Use of informal networks in using medicines*
- *Language issues as they shape medicine usage*
- *Role of physicians and pharmacists in shaping medicine use*

1. Tell me about the last time you used any medicine.

- What kind of medicine was it? [Is that a medicine that you need a prescription to get, or one that you can get on your own?] ***Go for facts/stories first and keep questions open ended until all participants had a chance to speak*** *(later on ask for clarifications, and lastly find explanations)*
- Tell me about any problems you had taking the medicine
  - Did you understand what your medicine was for and how you were supposed to take it?
  - Were there written instructions on the package or bottle? Did you understand them?
  - Did anyone explain to you how you were supposed to take the medicine? Who? [Did any family or friends help you understand or decide what to do?]
  - What happened when you went to the store to get the medicine? [Did you talk to a pharmacist? Did you understand what the pharmacist said to you? Did you feel that the pharmacist understood you? Did any family or friends help you with this?]
  - How could your experience with getting and using that medicine have been improved?
  - If you had to obtain refills, did you do something different?
- Why did you use it?
- Tell me about anyone who helped you use or get that medicine. [Did any of your family members or friends help you? How about any doctors or pharmacists? Include: deciding about use, obtaining medicines.]

If the conversation addresses primarily prescription medicines, revise the above and ask: Tell me about another time you used some medicine that you didn't need a prescription to get.

2. In general, when you're deciding about what kind of medicine to use when treating a problem with your health that is new or unfamiliar to you,

- What kind of treatment are you most likely to try first? [Would you try over-the-counter medicines first, or medicines that you get from a doctor, or something else? Why is that?]
- Which do you rely on more: family and friends, or doctors and pharmacists? Why is that?

We ask the last questions as a way of evoking new stories or allowing people to reaffirm patterns that were developed earlier.

Fig. 1 Focus group questions guide.

Table I Description of the Focus Group Participants (N=36)

Characteristic		
Gender	Men	28%
	Women	72%
Age	Range	51 to 82 years
	Median	65 years
Country of origin	Puerto Rico	47%
	Dominican Republic	22%
	Other (Argentina; Columbia; Cuba; El Salvador; Guatemala; Honduras; Mexico)	31%
Years living in the US	Range	0.5–51 years
	Median	18 years
Level of education	Range	0–16+ years
	Median	6 years
Self-rated ability to speak English	None or almost none	44%
	A little	35%
	Acceptable to well	21%
Self-rated health status	En crisis; fatal; malo; poor; very bad	17%
	Fair, no muy bien; no muy buena; poco normal	11%
	Bien, estable, good, normal, stable, regular	72%

and the difficulties associated with recruiting men for many studies. As well, efforts were made to ensure that at least half of the respondents were 65 and over, given the escalation of medication use that occurs in later life. The sample description presented in Table I indicates that our efforts were reasonably successful. Consistent with the national origin representation in Eastern Massachusetts, the largest share of the participants were from Puerto Rico with the next largest origin the Dominican Republic. Participants varied widely in terms of how long they had been living in the mainland United States, and most reported low levels of education. Nearly half reported poor English-speaking ability, but most regarded their health as quite good. As is the case for the majority of older individuals in the US, most reported taking one or more medications. Commonly listed conditions for which one or more medications were taken included diabetes; high blood pressure; high cholesterol; depression; and arthritis. Reflecting the health and welfare policy climate of Massachusetts, all but two participants reported that they were covered by some form of health insurance, and many indicated that their insurance included prescription medication coverage. Thus, economic barriers to obtaining medication were limited in their direct influence on behavior for all but a few of the participants.

All focus group sessions were audiotaped with permission from the participants. Taped interviews were transcribed and translated into English by a professional translation firm that specializes in translation and interpretation in medical and legal settings. The veracity of the transcripts was verified by two of the investigators whose first language is Spanish. The transcriptions were read carefully by all of the investigators, and discussed in detail. Subsequently, the English transcriptions were analyzed with the aid of NVivo 2.0 qualitative software. Given that our research purpose was to explore themes relating to challenges associated with medication use among individuals with limited English language skills, key words and phrases relating to these issues dominated the coding effort. Coding was completed primarily by the senior author, with input, assistance, and secondary coding completed by the other authors. The team coded each phrase after utilizing open coding to

define recurrent themes. Multiple themes surrounding obtaining and using medications were explored; for example, experiences talking with physicians about medications; experiences obtaining medications from pharmacies; and experiences dealing with concerns about side-effects and drug interactions. Some themes spanned these experiences; for example, themes relating to language barriers, feelings of being discriminated against, and the use of informal networks as a strategy for overcoming these multifaceted obstacles. It was not the purpose of our study to identify differences in experience between subgroups (e.g., between men and women). Given the exploratory nature of our data, we focused our coding efforts on themes that recur across groups.

We acknowledge that focus groups—perhaps especially within the context of an exploratory pilot study such as ours—cannot represent the full range of attitudes, beliefs, or experiences within a population. Our groups were selected with an eye toward capturing diversity in experiences, but they do not incorporate the full range of diversity within the older Latino population as a whole. We believe that our study reveals some important ideas and potential avenues of investigation that can be pursued through additional conceptual development and further research.

Results

Language is a barrier in dealing with medications

Respondents told numerous stories about clinical settings in which language posed a problem for receiving care. In addition, stories like the following suggest that pharmacies, as well as clinical settings, may be a source of frustration for older Latinos:

> Every time I go to get the medicine, if I don't take someone along who speaks English, it's a problem. I have problems there. [Because no one speaks Spanish?] No, not at the pharmacy. Not at the pharmacy.... Since I don't understand, all they say to me is 'No.' I laugh and I leave because it's my fault, because why haven't I learned a little bit of English? And I leave, then I say to my son, 'You go, because I don't understand that.'

Another participant told a similar story,

> My husband used to have a lot of problems... when he got his prescription from the doctor and he went to pick up the medicine. Sometimes he would come back with it {that is, the written prescription paper} in his pocket because he couldn't find anyone to help him.

These and similar stories suggest that challenges associated with limited English proficiency are not restricted to the clinical setting. Older individuals with limited English language skills encounter barriers to obtaining medications that reach far beyond the physician's office. A more holistic approach to remedying health disparities should take into account the behavior and interactions occurring among non-physician practitioners and pharmacy staff as well.

Language issues are seen as being linked to discrimination

Language barriers in medical settings were related to perceptions of discrimination on the part of the older Latinos in our study. The poor English skills shared by many of our

respondents were seen as a source of ridicule and as an excuse for poor treatment by physicians and pharmacy staff. For example, in dealing with physicians:

> I felt very bad because ... (the doctor) asked, 'How long have you been here?' I said, so many years. 'Well, why can't you speak English?' Because I came here to work, to raise my family, and time slipped by. I didn't know that was a sin. That's what I told him.

Similar experiences were reported in interactions at the pharmacy:

> In the pharmacy when they don't understand you, they give you dirty looks [she makes a blowing or sniffing sound]. And they go [loud sigh].

These stories suggest that for these older Latinos, limited English proficiency may serve as a barrier to forming respectful relationships with health care professionals.

Older Latinos are actively involved in their health choices

Despite these obstacles, the older Latinos with whom we spoke took active responsibility for their own health and health care. Most were reasonably knowledgeable about their health conditions; most expressed an interest in taking charge of their own care. These respondents reported that they paid close attention to their health conditions and reactions to medications, reporting any problems to their physicians:

> When they give me a new refill, for example, to know if they gave me the exact amount the doctor told me, I control that, whether they give me less pills or they give me more; I control all that. Because I have to report to the doctor. In fact, when I check my sugar I have to give the doctor a report of what the reading is every day. And I am very careful because I like myself very much.

In the discussions, the respondents' involvement in their own health care is frequently linked to their understanding of the medicines taken and their relationships with physicians:

> And when I see that a medicine is not producing the reaction I expected, I call the doctor and I say, 'Look, I'm going to suspend this medicine; it's causing such and such a reaction.' He immediately says, 'Suspend it.' Besides, a doctor isn't a magician, so I help them with things that are happening to me.

And, from another informant:

> I feel that if you are a patient and I have a good doctor, we should be friends, and talk about medicine.... In other words, it's my habit to talk to them and tell them.... I give them clues to my problem, too. I say, 'Look, doctor,' because I've dealt with doctors for a long time, and I've always been like that. Ever since I was young and started having my children, I have liked to talk to doctors about the problems and the medicines. And that has helped in the way they treat me.

These stories reinforce the value of good communication and trusting relationships for our older informants. The older individuals with whom we spoke are actively engaged in their health care, and seek to make informed choices about medications. Comments made by those who have formed good relationships and successful strategies for communicating with providers suggest that good communication is a key to satisfactory health care experiences. For others, communication obstacles are problematic if they prevent full understanding and participation in decision-making.

Older Latinos develop numerous strategies for maximizing their understanding

A key goal of the study was to identify strategies by which language barriers surrounding the use of medications were overcome. According to our informants, using family and friends as interpreters and sources of help is a key strategy. Seeking out Spanish-speaking health care providers and pharmacies with Spanish-speaking staff was also frequently mentioned. Issues and challenges associated with using formal interpreters were also discussed.

In our discussions with older Latinos, family and friends were frequently identified as sources of assistance with medical concerns and as interpreters. With respect to helping with medical issues:

> I think I have always had my children take me. They take me because I can't do it alone.

Informal networks are also used to help deal with pharmacy staff, as another informant explains:

> Yes, there are problems {at the pharmacy} because I don't speak English. Sometimes when—for example, last time, I had a cold and I had to take my uncle, I said to him, 'Let's go' so I can tell what the man is saying. It's the only way because...the truth is, I don't understand him.

Moreover, family and friends are used on a day-to-day basis to translate the directions on medications:

> Over where I live there is a lady who knows a lot of English. I say to her, 'Look, you know English, please tell me what it says here.' It has to be someone I know. Or else I'll ask Maria, my daughter.

Respondents reported that they sought out Spanish-speaking physicians to ease communication barriers. Many stories linked the Latino ethnicity of their physician to the respondent's own feelings of confidence and competence with respect to taking medicines. Respondents frequently reported feeling knowledgeable about the medicines they were taking because their doctors explained the issues thoroughly. For example:

> I have a Hispanic doctor...who tells me for each medicine what each one is for.

And, from one particularly articulate informant:

> Me, for example, I understand English well, I read it, I speak it and I prefer to go to Hispanic doctors. Because I also believe there is a psychological affinity, in addition to the rules code, I think there is a good feeling.... the security one has when one has a simple knowledge, and that one is spoken to in Spanish of the... of the people, because there are some who appear to have a doctor's diploma above and they use the terms there of...[That can't be understood?] Scientific terms and I say 'well, look, speak to me in Spanish' so I can assimilate it... and one can progress more, get better....

However, some respondents indicated that it was not necessary for the physician to be Latino him or herself for good understanding to be perceived. Rather, speaking even a little Spanish led to feelings of understanding:

> My doctor also explains what the medicine is for. [And does he explain it in Spanish or in English?] In Spanish. My doctor isn't Hispanic but he speaks Spanish.

And, from another participant,

> [Tell me, does your doctor speak Spanish?] A little bit. [Do you speak English to him?] No, Spanish. [Spanish—so how do you understand each other?] Because he speaks some. That's the thing.

In the absence of a Spanish-speaking physician, use of formal interpreters is a familiar strategy reported by many respondents. For example:

> I walk to the hospital and they... I don't know much English and they get me an interpreter and I do all right.

However, the system for using formal interpreter services frequently provides less than optimal satisfaction. For example, another participant reports difficulties associated with using interpreters:

> When I have an appointment—not with my regular doctor because he speaks Spanish, but for my eyes or for some tests they are going to do or something—I have to wait two or three hours to get an interpreter.... And sometimes I have even missed doing what they were going to do that day because there is no interpreter.

Obtaining and effectively using pharmaceuticals requires more than just communication with a physician, however. As noted earlier, obtaining medicines at pharmacies is cited as a familiar challenge for those who do not speak English well. Our older Latino respondents typically had worked out strategies for obtaining medications that involved the use of informal networks and nonverbal communication. For example:

> Well, when my medicines run out, the 28th of this month, I have to order them the day before. So, since I live with my daughter, I say to my daughter, 'Look, order the medicines for me from the pharmacy.' And she orders them over the phone. So the next day, what I have to do is take the card of the Plan, and they look up the medicine for me right away and they give it to me.... I have to take the vial with me because since I don't speak English, by telephone I don't understand.

Other respondents sought out pharmacies with Spanish-speaking staff as a way to facilitate obtaining medications. For example, the woman reporting that her husband sometimes came home with the prescription papers still in his pocket, having been unable to find anyone to help him at the pharmacy, indicated that this problem was resolved with cooperation of his physician and with the hiring of Spanish-speaking staff:

> He says, "Well," he said to the doctor, "I have a problem with this. Why don't you call the pharmacy so that they will give it to me, or see what you can do about it?" So when he goes, what the doctor does is he calls the pharmacy to have them give the prescription to him. But they have a Hispanic girl there now.

and

> We're fortunate to go, in this pharmacy here in C. they speak Spanish. There's no problem. [Aha. Is there always someone there who speaks Spanish?] There's always someone. It's rare that someone isn't there.

Similarly,

> I get my medicine at [name of pharmacy] and they give me directions and everything in Spanish. [Aha, written?] Yes, written.

Thus, for this group of limited-English proficiency older Latinos, a variety of strategies are pieced together to solve the problem of communication barriers. When possible, Spanish-speaking physicians and pharmacy staff are preferred. However, informal strategies making use of bilingual family members and friends are common, as well as use of formal interpreter services.

Trust is a key component of patient decision-making, and trust is related to language

Throughout the interviews, it was evident that medication use is intrinsically linked to the relationship between patients and their providers, and especially to the level of trust developed between the two. For example, in describing two different interactions, this informant equates shared language with *real* communication:

> And thank God, that doctor is a doctor that people appreciate very much because she cares about her patients, she devotes time to you, she talks to you, she asks if there are any questions, she looks up your record, and things that you don't even remember, she says, 'Look, what about this, how is this doing, how is that doing?' .... I used to have another doctor before; that's why I switched. She didn't speak my language. She was a—you had an appointment and it was really quick. You left there like—the interpreter arrived and she said this and that and the other, and you left there without knowing. You had no means of communicating with her....'

This respondent links the issues of respect and trust to language:

> I am very grateful to the doctors. They treat me with a lot of respect, a lot of caring, a lot of attention, because of the many problems I have, to avoid any complications. Despite the fact that I am Latina. But I get along with a doctor in English, too, thank God.

And, perhaps mostly directly, this informant highlights the important link between communication and trust in defining a successful relationship:

> I trust them, so they trust me too.... I help the doctors to control my problems too. I talk a lot with them.

The importance of a trusting and respectful relationship for these informants may form the basis for some dissatisfying experiences surrounding the use of formal interpreter services. According to our respondents, the veracity of the interpretation is sometimes doubted. Some of the older Latino respondents report that they simply do not trust that the interpreter is providing an accurate account of what is being said.

> For the matter of my vision, I go with my daughter. Or with my son.... In these cases, it's better to take a family member because that way, you remove doubts of whether they are saying the truth or not.

Similarly, from another informant,

> Sometimes, you speak to a doctor through the interpreter and they don't tell the doctor what you said. They say something different. Because it has happened to me many times. [And how do you know they're saying something different? Because you know some English?] I know English. And sometimes you say one thing and they say another thing. It has happened to me often, and I've heard from others, too.

For these informants, understanding and trusting is a critically important part of a good relationship with a medical provider. Although interpreters can help overcome some of the

barriers to communication, they may not benefit from the formation of a trusting relationship, especially if the veracity of the interpretation itself is in doubt.

Discussion

Our study suggests that language barriers may have implications for medication choices and medication adherence on the part of older Latinos. Inasmuch as a great deal of medication use in later life surrounds the treatment of chronic and potentially life-threatening conditions, this relationship may be one source of health disparities between Latinos and non-Latinos and deserves additional scrutiny. In our discussions with older Latinos about their medication use and health-seeking activities, language barriers were prominently mentioned. These barriers were problematic because they hindered our informants' understanding of their health conditions and of the medications prescribed. They were also problematic because they formed an obstacle to developing a trusting and respectful relationship with health providers. Seeking out Spanish-speaking physicians and pharmacies and using family members and friends as informal interpreters were commonly used strategies designed to create better and more trustworthy understanding.

The participants in our group interviews provided insight into a process relating to health seeking and taking medicines that is reflective and based on active decision-making. Similar to the process described by Stoller, Forster, and Portugal (1993), our older Latino informants are actively involved in their care when making decisions about medicines. These decisions appear to be linked to their understanding of the health conditions with which they are dealing, and also with the relationships perceived by our informants with their health providers. Similarly to that described by Stoller (1998), individual response to symptoms or health experiences may be shaped by the "social interactions" surrounding illness and wellness.

How does language fit into this process? Our findings suggest that language is relevant neither exclusively as a proxy for cultural health beliefs, nor simply as a barrier to technical understanding of medical issues. Certainly, language does play a structural role in shaping medication practices: the reflective, personal assessment process surrounding medication use is necessarily based in part on the patient's understanding of her health condition and the treatment prescribed by the health provider. However, the role played by language appears to be more multidimensional. Indeed, language (and here, proficiency in English) could be construed as a relational dimension in which *trust* and *respect* play larger roles than does the literal understanding of the language. This is reflected in the extent to which language barriers are related to perceived discrimination or, conversely, perceived respect among the patient and health care providers, pharmacy staff, and others involved in health-seeking. It is also reflected in the extent to which information about health and medicines, and the sources of that information, are trusted. The quality of the relationship between our older Latino informants and their health advisors appears to shape the perceived trustworthiness of the information obtained from those advisors. This relationship quality may be strongly shaped by language and the perceived ability to communicate (see Weitzman *et al.*, 2004, for similar conclusions).

Thus both *understanding* and *believing*, or trusting, are critical aspects of encounters between older Latino patients and providers. Direct communication with providers who speak the same language is preferred by our Latino informants, both because understanding is enhanced and because true communication and confidence in the information received is

more likely. When direct communication is not possible because of language barriers, an intermediary is often used. Formal interpreters are familiar to our Latino informants, but are sometimes less preferred, primarily because they are considered to be less trustworthy sources, especially when they are not known to the informant. The use of family members or friends as interpreters is described more positively. The benefit to our informants of using informal interpreters is expressed both in terms of convenience (informal interpreters are often readily available) and in terms of trustworthiness (informal interpreters can be trusted to convey information more accurately, in the opinion of our informants).

We are reluctant to offer any strong conclusions based on this small, qualitative study of older Latinos in eastern Massachusetts. The health policy and health care climate within which our subjects are seeking services and medications may shape their experiences in ways that are not shared by Latinos in some other geographic areas. We do regard our findings as intriguing and warranting further examination. For example, if language barriers between patients and health providers inhibit compliance because patients do not trust the information received in medical encounters, strategies designed for clinical settings that focus purely on literal interpretation may not have the desired benefit. Alternative strategies that emphasize both understanding and trust may be required.

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