

AN EVALUATION OF A BILINGUAL PREOPERATIVE  
INSTRUCTION GUIDE FOR THE MONOLINGUAL  
SPANISH-SPEAKING PERSON

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We hereby recommend that the Thesis prepared under  
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## CHAPTER I

### INTRODUCTION

Health care is being challenged more each day with modern-day realities. The challenges and expectations toward high-quality care are, more than ever, a reality of the present. People are demanding to be treated as individuals with individual needs.

When an individual enters unfamiliar surroundings and delivers himself into the hospital's care, he gives up much or all of his independency. He also becomes separated from his family. The staff personnel will enter and leave his room at will and his personal identity must be lost in the maze of continuous activity. Throughout this admission process, the newly-admitted patient's constant companion may be fear. Perhaps the patient fears an operation and pain, or perhaps this same individual fears dependency and the unknown. To the monolingual Spanish-speaking patient, the greater fear is the unknown and the possibility of being unable to communicate needs. To communicate to this patient even the very basics of care is a challenge for the nurse.



An important factor that can influence communication with a patient is the nurse's ability to communicate verbally. Verbal communication is an essential part of promoting comprehensive health care. Patient anxiety and nurse frustration is imposed when cultural backgrounds create language barriers. In addition, the patient's postoperative rate of progress may be significantly impeded as a result of communication difficulties.

Directly or indirectly, the nurse is responsible for alleviating some of these problems which present themselves as physical, emotional, or social setbacks. Because of the importance of individualized patient care, it was felt that a research study dealing with the area of verbal communication was needed.

#### Statement of the Problem

The problem of this study was to determine the effectiveness of a phonetic bilingual preoperative instruction guide for the monolingual Spanish-speaking person utilized by the monolingual English-speaking nurse.

#### Purposes

The purposes of this study were:

1. To develop a tool to set up basic communication between the monolingual Spanish-speaking person and the monolingual English-speaking nurse; and

2. To determine if the phonetic preoperative instruction guide provided effective communication.

### Background of Significance

Spanish-speaking people are composed of several cultures and subcultures. Viewed as a group, they are not identifiable by any one single criterion, but rather by multiple characteristics. According to Saunders "the characteristics include such areas as physical appearance, name, language, dress, place of residence, and general deportment, most of which convey cultural or subcultural meanings to everybody" (1954, p. 43).

A great number of the Spanish-speaking population is concentrated in the southwestern part of the United States. Approximately five million Mexican-Americans form the largest single part of this Spanish-speaking population. They are primarily concentrated in Arizona, California, and Texas (Galarza 1970). About four hundred thousand of the Spanish-speaking population are of Spanish-American descendance, and live predominately in New Mexico and Colorado (Saunders 1954). The remainder of the Spanish-speaking population are Mexicans, immigrants who are legally Mexican citizens. They are located primarily along the commercial agricultural areas of California and Texas.

Their numbers change considerably from day to day (Saunders 1954).

Wherever the concentration of Spanish-speaking people is located, the tendency to live together in separate communities or to inhabit separate and distinctive areas of a larger community is evident (Rubel 1960; Saunders 1954; Baca 1969; Schulman and Smith 1963; Galarza 1970). The reason for this segregation is that the Spanish-speaking population and their customs strongly prevail in separate communities or areas known as "barrios" or compounds (Baca 1969). In these separate communities, Spanish is preferred to English as the everyday language, and Anglo customs and habits are not readily adopted. Saunders notes that "Anglo ways, except for those involving the acquisition, possession, and use of material objects are not well understood nor widely produced. Association is mainly with other Spanish-speaking people . . ." (1954, p. 43).

It is important to mention that not all Spanish-speaking people follow the same pattern. As Macgregor (1960) indicates, class differences will need to be taken into consideration. Spanish-speaking people, whether from the upper-class, middle-class, or lower-class all possess some variation in their habit patterns, responses, preferences, and value systems. Also, the individual

Spanish-speaking person's command of the English language may give him more confidence to venture away from the strictly Spanish-speaking communities.

An important factor in working with the Spanish-speaking patient who clings to his cultural heritage is his ancient beliefs concerning health and illness (Baca 1969). Traditionally, the Spanish-speaking person draws on folk medicine as a means to treat ill health. Leininger (1970) acknowledges that when Spanish-speaking persons seek out an Anglo-American practitioner, it is only after they have experienced no relief or success from their culturally-derived remedies.

Bullough and Bullough (1972), after conversing with monolingual Spanish-speaking patients, arrived at the conclusion that a visit to a physician who speaks only English or a hospital stay where the personnel speak no Spanish is frightening and not particularly fruitful. The language barrier between the patient who speaks only Spanish, and the medical personnel who speak only English presents a problem to verbal communication. The information exchange between the patient and the physician or the patient and hospital personnel is apt to be meager because few Anglo-American health professionals in the Southwest speak Spanish. Suchman (1965) perceives that the

monolingual Spanish-speaking patient views his dependent role with ambivalence. He may wish to avoid the entire situation, but may see it as the only possible way to achieve re-entry into his normal roles. Macgregor states:

The rituals of bathing and exposure, shaving, preparation for surgery, taking blood samples, enemas, cathartics or emetics all encounter some one or other of these attitudes. Sometimes a not too pleasant experience, occasionally an unbearable trauma (1960, p. 17).

In the past, the nursing profession has given special emphasis to the physical and psychological care of the patient. The social and cultural aspects related to health care and illness were perceived as less important (Leininger 1970). Gradual recognition is now being given to the manner in which cultural factors do play an important role in health maintenance and illness. When cultural backgrounds differ, a common ground for understanding should be sought and established. In taking an approach toward promoting communication, improved individualized nursing care takes place (McCade 1960). Alford (1962) reinforces this idea by affirming "communication, both verbal and non-verbal, is an essential part of good interpersonal relationships." With the monolingual Spanish-speaking patient, a language barrier could prevent efforts to promote and maintain interpersonal relationships.

More patient involvement, as in patient education, should be promoted with emphasis in the area of preoperative instructions. Patients about to have surgery should be given simple careful explanations of what is expected of them from the hospital personnel. This important step in patient teaching would do much to alleviate fears and dispel fallacies (Levine and Fielder 1970).

A study under the direction of Healy (1968) was undertaken concerning the value of carefully given preoperative instructions. Over 300 patients having elective surgery were followed from admission to discharge. One hundred eighty-one of these patients received specific instructions, demonstration, and supervised practice concerned with preoperative care. The patients in the control group received preoperative instructions with fewer details. At the end of a four-month study, the information was collected and data showed the following:

1. Of the 181 experimental patients, 135 went home three to four days prior to the expected day of discharge.

2. Of the 140 patients in the control group, only 3 patients were discharged prior to the anticipated date.

3. Of the 181 patients in the experimental group, 160 began oral narcotics on the fourth postoperative day, 1 went off all medication on the sixth day.

4. Of the 140 patients in the control group, oral narcotics were still being used on 127 patients on the sixth day and 13 patients were on parenteral narcotics on their day of discharge.

5. There were three complications noted in the experimental group and sixteen complications in the control group.

In summary, Healey (1968) believes the value of setting aside a definite time in which to give structured preoperative instructions does make a significant difference in the delivery of organized care. As a result of the study, the personnel involved were motivated to improve in their organization of patient care. There was also more team work between the nurses and the patients when organizing a plan of care.

For the presurgical patient with a language barrier, communication concerning preoperative instructions is even more essential. Otto (1965) stresses the major contribution to the patient lies in what the nurse is able to communicate to him about himself and his future. It would be beneficial to both the nurse and the patient to become

involved in more active participation toward bridging the communication gap. Such action would do much to create less fear and anxiety for the monolingual Spanish-speaking patient (Saunders 1954). The nurse is also rewarded. She experiences self-satisfaction in her role as a nurse. In addition, she adds to her skills in communication (Lewis 1965).

#### Hypothesis

The following hypothesis was tested:

The phonetic preoperative instruction guide provides basic communication between the monolingual Spanish-speaking person and the monolingual English-speaking nurse.

#### Definitions

For the purpose of this study the following terms were defined.

Monolingual--a person who speaks only one language.

Culture--the total pattern of human behavior with standardized social characteristics belonging to specific groups.

Spanish-speaking--one common language spoken, Spanish.



Spanish-speaking population--a population made up of three major subgroups: Spanish-Americans, Mexican-Americans, and Mexicans.

Spanish-American--a person with genetic descentance from Spain.

Mexican-American--a person born in Mexico who applies for and receives United States citizenship; or one who is the child of parents or grandparents born in Mexico.

Mexican--a newcomer to the United States, who is legally a Mexican citizen.

Southwest--area of the United States consisting of California, Arizona, Colorado, New Mexico, and Texas.

Anglo--a United States citizen whose primary language is English.

#### Delimitations

Delimitations for this study were:

1. The student nurse understood and spoke primarily only English.
2. The Spanish-speaking person understood and spoke primarily only Spanish.
3. The Spanish-speaking person was of a well-health status.
4. The student nurse was in a baccalaureate nursing program.

Limitations

The following limitations were taken into consideration for this study.

1. There was no control over the relationship between the nurse administering the tool and the Spanish-speaking person.
2. There was no control over the nurse's previous experience and/or exposure to the Spanish language.
3. There was no control over the Spanish-speaking person's experience with/or exposure to the English language.
4. There was no control over the immediate home setting.
5. Varying differences in the anxiety levels existing between the healthy Spanish-speaking person and the hospitalized Spanish-speaking patient could not be controlled.

Assumptions

For the purpose of this study, the following assumptions were taken into consideration.

1. Verbal communication is desirable.
2. The principal function of verbal language is to facilitate communication.

3. Establishment of nurse-patient communication is an important nursing goal.

### Summary

The most complete form of communication between two people is verbal language, for it is used to express meanings that provide information in a given situation. When a language barrier exists between the presurgical patient and his nurse, communication can be reduced to an almost non-existent level. Without a method to provide communication, the nurse is unable to deliver adequate instructions so that the patient can become an active director of his care plan. In being able to bridge the language barrier, even in its most basic form, the nurse will have progressed and added to her skills as a health-care practitioner. When learning a foreign language, one usually tries to reproduce another's speech in a manner that is understandable to him. The significant sounds will have a more or less mutual correspondence with those of his own language. This particular study utilized these sounds (phonetics) to communicate preoperative instructions to the monolingual Spanish-speaking person.

Chapter II presents a review of literature pertaining to the need for communication between the nurse

and patient who are culturally attuned to two different life styles. Chapter III, Procedure for Collection and Treatment of Data, describes the Bilingual Preoperative Instruction Guide, the questionnaire, and the evaluation tool utilized for "patient" responses, how they were developed and validated. Chapter IV, Analysis of Data, elaborates on the treatment and statistical analysis of the data obtained. Chapter V, Summary, presents recommendations, implications, and conclusions regarding the findings of the study along with suggestions for future studies.

## CHAPTER II

### REVIEW OF LITERATURE

Communication is fast becoming the social matrix of modern life. Today, in the twentieth century, communication is binding people together. It is a means of sharing through interaction an awareness of people as total individuals. Without communication, effective social interaction is both hindered and incomplete. An individual is unable to refine his skills in interacting and responding with another individual, or a group of persons. The ability to share ideas, opinions, values, and feelings is a communicative process without which people cannot advance.

#### Communication Theories

Communication is in every way, shape, and form, a part of everyone's life. It is overpowering. Lundberg (1939, p. 274) perceives communication as interaction of signs and symbols that reduce tension and promote understanding. Cherry (1966, p. 6) interprets communication to signify sharing elements of behavior, or modes of life through existing sets of rules. Barlund (1964, p. 200) regards communication as an essential human need that

arises to reduce uncertainty, to act effectively, to defend oneself or another, and to strengthen the ego. Still, another expert defines communication as a process that involves the selection, production, and transmission of signs (Fotheringham 1966, p. 254). This process would be arranged in such a manner as to help a receiver perceive a meaning similar to that in the mind of the communicator. In total, communication as defined by the review of literature, is tremendously broad in scope and meaning. Keeping within the parameters of this study, Berlo affirms that, "all communication behavior has as its purpose, its goal, the production of a response" (1960, p. 12).

In reference to reviewed literature on communication, there are four specific theories which pertain to various communicative processes (Thayer 1968; Cherry 1966; Frank 1956). The four interrelated, yet distinct dimensions of theory, view communication as: (1) a system of behavior, (2) a decoding-encoding activity, (3) an interaction, and (4) within a social context (Cherry 1966).

As a system of behavior, an idealized description of what is necessary for an act of communication to occur is inferred. This would involve a sender transmitting a message to a receiver. In conjunction with the sender and the receiver, other factors are taken into consideration:

(1) the nature of the interaction, (2) the response to the message, and (3) the context in which the interaction occurs.

In evaluating the nature of the interaction, though one physically transmits signals or signs, this alone would not constitute communication. The sign or signal, as perceived by the receiver, must contain the potential for eliciting a response within him. The second factor in question, the response to the message, also undergoes similar scrutiny. When a person physically sends a message, by using his mouth or gestures, he sets up a response behavior from the receiver.

The third factor to consider in conjunction with the sender and the receiver is the context in which the interaction occurs. The specific situation concerning the sender and the receiver must warrant a purpose for communication to join them together. This particular theory provides a frame of reference to promote better understanding of the relationship from all communicative action (Serno and Mortensen 1970, pp. 7-8).

The second distinct theory views communication as a decoding-encoding activity. The decoder is identified as the receiver of communicative activity. The encoder represents the sender of transmitted activity. Still, a third factor, interpretation of the activity, is included

(Berlo 1960). One expert (Read 1972, p. 26) refers to the interpretation of the encoding-decoding activity as a telephone line connecting the encoding telephone to the decoding telephone.

The third communication theory, interaction, may be regarded as the process of uniting together the senders and the receivers of messages. Almost any type of behavioral condition could influence the uniting process. A gesture, an attitude, a conflict, or even tension are examples of behavior that influence the uniting process. As long as the signal is capable of being interpreted meaningfully, an interaction has been initiated (DeVito 1971, p. 13).

Social context is the fourth and most complex theory of all. Communication is undergoing continuous change due to the variety of social settings available for social organization. Dance (1967, p. 293) observes that communication is something that changes even while one is in the act of examining it. But regardless of what method one employs, communication requires some kind of social context, such as a face-to-face encounter (Barlund 1968, p. 151).

It is an established fact that communication is an essential activity in man's need to maintain contact with



his environment (Parry 1970, p. 9). Since man uses communication on a continuous basis, one can surmise that it has a purpose. As stated previously, it is designed for transmitting and transferring an idea or group of ideas.

### Human Communication

Pace et al. (1973) regard the scope of human communication to include the term "interpersonal." Interpersonal denotes face-to-face encounters whereby persons engage in some form of verbal and nonverbal exchange. When man shares an idea with another person, he is involved in an interpersonal relation. O'Brien (1974, p. 15) considers this process important in directing man toward becoming more human and social. Shakespeare in "As You Like It" proclaimed that the whole world was a stage and every man a player. This statement projects greater meaning as one begins to understand the interpersonal relations of man. He transports himself into another person's world so that he may see and respond to events and ideas as the other person does (Keltner 1973).

In the nursing profession, one goal is to be helpful to individuals who require any measure of health care (O'Brien 1974; Lewis 1973). In order to carry out this

goal, the art of communication would be an essential factor. It is a central part of everything one does in life. Communication skills promote effective care for the patients who need health care (O'Brien 1974). The nurse is often exposed to patients having a variety of health problems, specific needs, goals, and different values. Therefore, the challenge to adjust and practice one's communication skills is frequently put to the test (Riffenburgh 1966).

#### Language: A Basic Approach

Language is basic and essential in daily living. It is a method by which people think and discuss ideas. Language fosters, organizes, and makes sense out of reality (Meyers and Meyers 1973, p. 66). In essence, language shapes the world that everyone knows. To quote Miller, "communication binds people together, and, of all the ways people communicate human language is the most important" (1973, p. 1).

Language consists of vocal signs. In comparing the sounds of two languages, the way that they are put together, denotes the difference. The most basic unit of a language is at the phonemic level. The phoneme, as defined by Gleason, is a class of sounds which are

"(1) phonetically similar and (2) show certain characteristic patterns of distribution in the language or dialect under consideration" (1955, p. 162). Lockerby (1968, p. 10) defines the phoneme as a speech sound, and contends that the English speech uses thirty-six sounds. She further elaborates that in any language, a word consists of one or more units of sounds (phonemes). These units of sound are heard and mentally processed by the intended listener. The concept is that correct pronunciation and distinct enunciation of the words ensure the listener's clear reception (Lockerby 1968).

In accordance with Panconcelli-Calzia (1957), speech was symbolized by primitive people in various ways. One of the more common and the earlier known methods was zig-zag lines drawn between two sketched human figures. The zig-zag lines indicated vocal communication. Moses (1964, p. 33) proposes that the initial recognition of the phoneme probably came about when people first attempted to set down their language by means of an alphabet, in place of a pictorial system.

Regardless of what promoted the organization of the phoneme, one outstanding development is clear. Human civilization is made possible by man's ability to share

verbally his experiences and exchange his ideas. He transmits knowledge from one generation to another (DeVito 1971, p. 4).

Several attempts are being initiated toward understanding language, its setting, and the interaction involved. Burling (1970) identifies meaning, social organization, and individual variability as three factors that influence the use of language. Meaning denotes the significance of the message expressed. The intended purpose of the message is for a specific interpretation to occur. Social organization relates to specific variables: (1) the class and status of the speaker, or (2) the formality of the subject in which he speaks. Individual variability pertains to the speakers. The variability could involve social class or individual expression.

Language symbolizes social divisions, a particular position in a social organization, one's attitudes, and personality. Keeping these thoughts in mind, it is no wonder some of the foreign language problems in the nursing profession have become magnified. Words are designed to convey and transmit one's thoughts and ideas. Within a hospital setting, Muecke (1970, p. 53) considers nursing intervention dependent upon communication between the nurse and the patient. Lyons adds that ". . . we all use

language as a means of organizing other people and directing their behavior" (1970, p. 141). This brings to mind the effectiveness of the nurse's communication with the patient in relation to the manner in which she plans and delivers messages to him. If nurses are to be understood, they must speak the language of the listener (Kron 1970, p. 40). By utilizing language as the communication method, two important areas are penetrated: (1) the nurse is able to enter the patient's cultural world, and (2) the patient is able to respond more adequately to his nursing care.

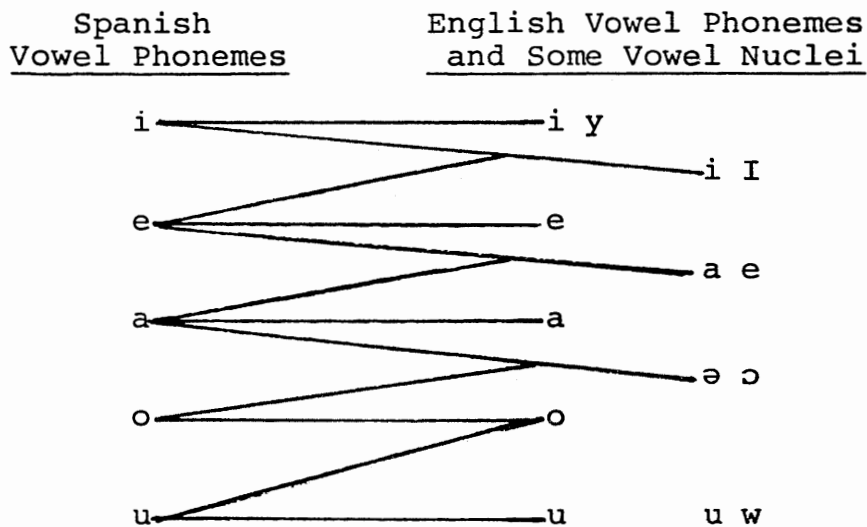
Anytime a language barrier exists, communication becomes drastically crippled. Language minorities, in particular, face special problems. In the United States, most of the information citizens are expected to have is communication in standard English (Study Group on Linguistic Communication 1973, p. 11). People who speak one language are unable to communicate with those who speak another. Human language is greatly useful as a means of communication, but it also has some inadequacies for expressing ideas (Miller 1973, p. 10).

Language is limited, but it can be rearranged to create expression for whatever is important enough to be considered necessary or desirable (Estrich and Sperber 1952, p. 103). In regards to foreign language and the lack

of some individual's ability to speak it, a device or method to bridge this gap is explored.

### Basic Characteristics

In accordance with Negrete (1961, p. 41), there are five Spanish vowel phonemes and nine English vowel phonemes. The illustrated diagram below exhibits a graphic comparison of the English vowel phonemes with the Spanish vowel phonemes. The diagram also depicts the vowel phonemes that English speakers are most likely to use as replacements for the Spanish vowels.



Since each foreign language has its own basic sound pattern for structuring words, denotations, and connotations between any two languages will vary to some extent. To be more specific, a language possesses three basic important features: (1) stress, (2) pitch, and (3) plus juncture.

The English language is said to have four stresses: primary, secondary, tertiary, and weak. The Spanish language has only three: primary, secondary, and weak (Negrete 1961, p. 54). The difference in stress systems between English and Spanish can cause difficulties for the individual when he attempts to pronounce Spanish correctly. The mispronunciation difficulties usually occur as a result of the individual's unconscious transfer of his English system of stress to the Spanish language (Negrete 1961, p. 54). To correct the misuse of stress, the individual is usually drilled and persistently corrected until he assimilates the Spanish stress system. To exemplify, stress is what makes the difference between the verb "torment" and the noun "torment" (Stockwell and Bowen 1965, p. 20).

In addition to stress, there is another feature that aids in communication of word meaning. Pitch or the differences in pitch give distinction to the various syllables pronounced. Spanish has three pitch or tone levels, though only levels 1 and 2 are commonly used. English has four pitch or tone levels, and levels 1, 2, and 3 are most commonly used (Negrete 1961, p. 56; Politzer and Staubach 1961, p. 66). The pitch levels normally coincided with the stressed syllable. When transferring an English pattern into Spanish, the person will pronounce patterns

that are more like English. In some instances, these patterns exist in Spanish, but they may have other implications. Depending on the pitch level, the English speaker may wish to convey a simple statement, but instead gives the Spanish listener the impression of being overbearing, disinterested, or bored. The pitch level differences would need to be explained so that the English speaker realizes the danger of being misunderstood (Politzer and Staubach 1961, p. 64). Politzer (1965, p. 37) elaborates further with the following illustration demonstrating pitch in a statement.

He has a <sup>head</sup> \ ache.

The same words spoken as an expression of questioning might become:

He has a \ head / ache?

When an individual approaches the Spanish language with intentions of learning how to speak it, the inflection of the voice is the first thing he notices and the last thing he masters (Stockwell and Bowen 1965, p. 19).

A major difficulty Spanish learners encounter lies in the linking of sounds between words. The English speaker is accustomed to a phenomenon known as open transition or



"plus juncture" (1 + 1 juncture) through which he hears a meaningful word boundary (Politzer and Staubach 1961, p. 61). The exact phonetic nature is difficult to define, but without plus juncture to signal word boundaries, the English speaker feels that the Spanish speaker is "running his words all together." Initial awareness of the natural phenomena, plus juncture, together with considerable exposure to Spanish exercises, is the usual solution to the problem.

Sound substitution, another area of language learning, requires mention. In the process of learning a foreign language, the speaker will unconsciously tend to substitute, for the foreign words, the nearest sounds from his own language scheme (Pei 1956, p. 79). Politzer and Staubach (1961), Negrete (1961), and Pei (1949) all agree that borrowing sounds or tones from one's own native language to construct a foreign word is not a stable approach for learning a foreign language.

### Cultural Consideration

Where there is a spoken language, there is a culture; the two are quite inseparable. Language, communication, and culture are terms which represent separate viewpoints for any individual. It is interesting how all three terms fit together to resemble interlocking pieces

that complete a meaningful message. To be more specific, a competent communicator (1) knows the other person's language, and (2) understands the culture in which he communicates. Message systems are supported by his cultural moves and motivations.

Culture, as defined by Harms ". . . is everything man learns from and creates through experience that he values enough to pass from one generation to the next" (1974, p. 12). It can then be surmized that human behavior is learned; one is not born with it. Culture is an elaborate mechanism; it makes life secure and continuous for groups of human beings. Culture is the sum total of what man learns in common with other members of his group.

Cultural patterns occur without any conscious design of the person who carries the culture. He is only aware that he feels comfortable and secure in what he holds in common with other members of his group. Placed in an unfamiliar situation where familiar cues have taken a different meaning, he could find himself psychologically unable to function. Exposure to this type of deprivation is defined as cultural shock (Toffler 1970). The individual, willingly or not, has plunged into an alien culture. Although the situation may be riskless, the culturally shocked individual is forced to struggle with unfamiliar

objects and events. Signs and sounds rush past him before he can grasp their meaning (Toffler 1970, p. 12). The only cure for cultural shock is quick identification of the imposing process followed by positive treatment of adjusting the individual to his immediate surroundings.

Culture provides security and comfort to the individual. It is valuable in protecting the physical and psychological health of the hospitalized patient. Within a hospital setting, cultural values affect the individual's perception of his illness and his immediate surroundings. In the provision of optimal health care for patients, sensitivity and response to their cultural needs are eminent (Leininger 1970, p. 45).

Within a hospital setting, one of the nurse's contributions to the patient is effective communication (Otto 1965, p. 32). To be more precise, the patient requires individual care that is culturally attuned to his own particular health needs. Without understanding or recognizing cultural aspects, effective communication cannot be accomplished. Holton (1965, p. 3) offers the clue that one recognizes what a man is (socially) by what he does (culturally).

As previously stated, cultural differences between nurse and patient affect the communicative process. Culture

plays a strong role in the communicative behavior of individuals (Borden 1971, p. 90). By rapid recognition and treatment of cultural shock in the hospitalized patient, the nurse alleviates tension and advances her communicative skills.

### The Spanish-Speaking Population

The Spanish-speaking population, second largest minority in the United States, is concentrated predominately in the southwestern states. It is described as a massive survival of underlying cultural heritage that includes language, customs, and economic status (Galarza, et al. 1970; Bullough and Bullough 1972). According to Moore (1970), no other foreign language or culture has so persistently adhered and is as likely to survive in the United States as Spanish. Spanish is used to communicate with foreign-born relatives and as a traditional habit. Spanish also persists because many Spanish-speaking people reside in isolated areas or neighborhoods referred to as "barrios" or "colonias" (Baca 1969, p. 2172; Galarza, et al. 1970, p. 19).

The Spanish-speaking person's understanding of illness and his ensuing behavior depend on his attachment to ethnic traditions. The older person, having minimal or no contact with the Anglo environment, retains most of his

health knowledge from Spanish cultural sources. The younger person, usually in greater contact with the Anglo customs, will share Anglo beliefs concerning sickness and use Anglo techniques to deal with it (Saunders 1954). One particular variable, economic status, plays an important part in influencing the Spanish-speaking person's health attitudes and practices. The poor members of this ethnic group, even when they live in the city, tend to cling more persistently to their traditional beliefs (Mustafa and Weiss 1968).

It is important for nurses to recognize the persistent practice of folk medicine within the Spanish-speaking culture. Ancient beliefs and practices concerning folk medicine can deeply affect the nursing care delivered to Spanish-American patients, for they are apt to reject anything foreign or contrary to their own tradition (Baca 1969; Clark 1959). Saunders (1954) recognizes the validity of cultural health attitudes in regards to who the individual is, where he lives, and personal experience. Saunders goes on to say that the Spanish-speaking person draws his knowledge of illness and treatment from four separate sources:

- 1) from the folk medical lore of medieval Spain as refined in several centuries of relative isolation from its source;

- 2) from the cultures of one or more American Indian tribes;
- 3) from Anglo folk medicine as practiced in both rural and urban areas; and
- 4) from 'scientific' medical sources.

In a given instance of illness, elements from any or all of the four sources may be utilized in any sequence that may seem appropriate to the individual or to those who may advise or otherwise try to help him (1954, p. 141).

In order to comprehend the presence of these four separate sources, certain facts need to be emphasized. The Spanish-Americans, Mexican-Americans, and Mexicans are the three major subgroups that comprise the Spanish-speaking population. Each subgroup has its own cultural ways, beliefs, and historical background. However, through time, there have been various kinds of interaction with other cultural and subcultural groups in the United States. These cultural interactions created the extraction of the Spanish-speaking person's knowledge toward illness and its treatment (Leininger 1970, p. 113).

Spanish-speaking people view the concept of health and illness in relation to God. Their belief contends that the ultimate cause of disease is a punishment from God (Clark 1959; Baca 1969; Bullough 1972). Clark (1959) asserts that disease is always connected with the idea of moral offense; rarely does it extend into the non-religious facets of life. The Mexican-American accepts various agents in his daily life as causing or provoking the disease.

Samora (1961, pp. 314-323) identifies some of these agents to be: shock (susto), as in fright or receiving bad news; body abuse (empacho), as in over-indulgence in eating or drinking; contact with the elements (mal aire) as exposure to a draft or getting one's feet wet; the evil eye (mal ojo), as in giving another person an admiring or covetous look that results in that person becoming physically ill.

The attitudes of Mexican-Americans toward health care in general and toward hospitalization in particular, significantly determine their use of health services. Clark observes that "for many Spanish-speaking patients, hospitalization represents the synthesis of all the most objectionable aspects of Anglo medical care" (1959, p. 235). Differences in concepts of disease, in language, and in orientation of time were cited as additional factors that affected health attitudes toward hospitalization (Mustafa and Weiss 1968, p. 37).

#### Patient Education

Communication is an integral part of nurse-patient interaction. Nurse-patient interaction is a necessary component in the delivery of patient teaching. Therefore, communication, nurse-patient interaction, and patient teaching are all interlocking parts of a goal: patient education.

Experts agree that nurses need to teach many things to the patient (Redman 1968; Lewis 1973; Kron 1971). The teaching and learning process is viewed as central to nursing. Hall (1964, p. 150) believes that through this process, the patient can come to grips with himself and will learn to be well. Through health teaching, the patient can become actively involved in his health care. Learning also helps the patient find meaning in the experience of illness, a natural common-life experience (Travelbee 1966, p. 13).

Teaching, as defined by Redman (1968, p. 4), is a special form of communication, structured, and sequenced to produce learning. She also sees all nurse-patient interaction as a contributing process toward patient teaching. Learning needs are essential for change to occur in a patient's responses to his state of health and to his environment. The necessary ingredient for learning to occur is the acquisition of knowledge. In this educational endeavor, the nurse assumes the chief role. She assesses the situation in question, plans strategy, carries out the plan of action, and evaluates the outcome of her efforts.

Nurses, through structured communication and information, guide patients to "recognize their health needs, to express their feelings about meeting them, and to



share in decisions about the means and the goals to be achieved" (King 1971, p. 99). It is, therefore, emphasized that the role of the nurse embraces teaching people about themselves and about the maintenance and promotion of health (Nursing Outlook 1972, pp. 46-52).

There will be times when teaching and educating the patient will not be easy. Communication may not flow easily between the nurse and the patient. In the instance of cultural and language barriers, teaching becomes an even greater challenge. Time, energy, creativity, and individuality will be the nurse's best tools to success (O'Brien 1974, p. 74). To bridge communicative problems, the nurse cannot succeed by putting forth minimal effort. The challenge of exploration and development of new skills, both instills hope in patients, and aids to clarify professional use of self (Lewis 1973, p. 99).

In searching for a preferred method of teaching, consideration is given to the patient, the nurse, and the subsequent interaction. Muecke advocates various ways to communicate with the monolingual Spanish-speaking patient:

- (1) Have multilingual personnel register their talents at an information desk.
- (2) Talk with the patient's family who speaks some English.
- (3) Know and speak some Spanish.
- (4) Use a dictionary with some imagination, drama, pictures, or simple phrase lists (1970, p. 54).

Good Samaritan Hospital in Phoenix, Arizona, has a special preoperative teaching program for the patient with a language barrier (Healey 1969, pp. 37-43). They have developed the teaching aide "Color Me Green." The booklet contains twenty-six 8 x 10 color photographs illustrating events that occur and the care involved when a patient goes to surgery. The booklet also describes postoperative conditions and the equipment used during this time. The photographs are accompanied by English and Spanish points of emphasis with which the patient and his family should become familiar. This program is based on the belief that through structured preoperative teaching, patients understand important aspects of their care. They are taught to be responsible for their own convalescence and rehabilitation. Healey concludes that the preoperative patient teaching program at Good Samaritan Hospital is seven years old and still subject to change and growth. She does not discuss to what degree the patient learns from the preoperative teaching program nor what educational goals are attained.

A second study, also conducted by Healey (1968), was undertaken concerning the value of giving carefully preoperative instructions. The results of this study are previously stated.

Any attempt by the nurse to convey teaching is generally accepted as an effort of interest by the monolingual patient (Lewis 1973, p. 20; Baca 1969, p. 2175). Language may be a barrier between a nurse and a patient, and it may pose temporary problems in teaching, but if nurses are conscious of the barrier, they can find methods to overcome it and communicate with patients (Muecke 1970, p. 54). De Tornyay cites some principles of learning for the promotion of patient teaching in difficult situations.

- (1) Provide positive reinforcement--show approval for an action by using verbal or nonverbal praise. The more obvious verbal words of praise are 'good' or 'fine' or 'yes.' The nonverbal gestures of praise are by nodding or smiling approval.
- (2) Use of examples and models--the use of self to demonstrate how one must do a deep breathing exercise would provide the patient with a model and an example of how to deep breathe.
- (3) Motivation--this can be introduced in a role-playing situation with exaggerated acting where the learner is to catch the point of emphasis. An example of this would be going through the motions of shaving one's face (in pantomime), then indicating to the patient to do the same, but give him a razor (1971, pp. 19, 24, 45).

#### Preoperative Instruction

The anticipation of undergoing surgery, whether it is a major or minor procedure, produces psychological reactions of fear and anxiety for most patients (Pleitez

1972). A certain degree of fear and anxiety is normal for any individual. However, if one is unable to secure any information about his situation ". . . his level of anxiety and tension is not likely to decrease; in fact, it is more likely to rise" (Mumford and Skipper 1967, p. 129). Preconceived ideas and imaginings will tend to distort and exaggerate the facts.

Simple, careful explanations concerning procedures before, during, and after the surgery do much to alleviate fears (Levine and Fielder 1970). Janis, an authority on psychological stress, observes that:

If a person is given appropriate preparatory communications before being exposed to potentially traumatizing stimuli, his chances of behaving in a disorganized way, or suffering from prolonged sensitization effects may be greatly decreased (1958, p. 353).

Well-defined basic information allows the presurgical patient to cross from an area of fear to one of security. A person will fear that which is unknown much more than what he knows to be unpleasant (Weiler 1968, p. 1465).

Preoperative teaching is generally presented in two forms: structured or unstructured. In a particular study, Lindeman and Aerman (1971) decided to investigate the effectiveness of both a structured and an unstructured preoperative teaching program. It was hypothesized that structured preoperative teaching would significantly

- "1. Increase the patient's ability to deep breath and cough effectively.
- "2. Reduce the patient's average length of hospital stay.
- "3. Reduce the need for postoperative analgesics."

There were 135 subjects in the control group and 126 subjects in the experimental group. In the unstructured preoperative teaching, general statements were made, by the nurse, about the need to deep breathe, cough, and turn postoperatively. Structured preoperative teaching consisted of a step-by-step plan of action with specific preoperative instructions. The outcome of the study clearly indicated the following:

- "1. There were higher scores for the experimental group on the ventilatory function tests.
- "2. The length of hospital stay for the experimental group was 1.906 days shorter.
- "3. The difference between both the experimental group and the control group was not significant concerning analgesics."

Structured preoperative teaching was found to be more effective, less difficult, and less frustrating for both the nurses and the patients. Mohammed (1964) also advocates that concerned nurses, interested in patient-centered care use structured oral and written communication that can be understood by patients.

It is generally agreed patients going to surgery are apprehensive, fearful, and anxious. When simple information concerning operative procedures and the patient's expected postoperative role are expanded, fears and

fallacies are dispelled (Levine and Fielder 1970, p. 27). This is an example of effective communication. Then there is the presurgical patient who is not culturally attuned to his hospital surroundings. He does not speak English, and he is definitely in need of preoperative instructions.

Information concerning the monolingual Spanish-speaking presurgical patient is limited, but the evidence is clear that he also is fearful and stressed about his impending surgery. The fears and fallacies are there. Bullough and Bullough mention that there are ". . . stories of patients who were taken to surgery who did not know they were going to be operated on" (1972, p. 77). To eradicate this type of story, patients need to be better informed and prepared for their surgical procedures. By communicating preparatory surgical information to the patient, misconceptions are thus avoided.

Prior to surgery, the patient is given information and taught certain basic preoperative procedures. These basic procedures will promote a better understanding of postsurgical activities that will allow the patient to overcome discomfort, and permit him to participate actively in his care (Moidel et al. 1971, p. 460). Demonstrations of preoperative exercises and practice periods, prior to the impending surgery are helpful to the patient. The

basic preoperative information that should be communicated to the patient is contained in the following list.

1. Inform time that surgery will take place-- psychological preparation for the patient should begin as soon as possible (Moidel et al. 1971, p. 458).
2. Demonstrate deep breathing and coughing-- promotes respiratory function and is effective in removing mucus from the lungs (Beland 1970, p. 761).
3. Discourage smoking prior to and following surgery--smoking increases the likelihood of respiratory complications during and after surgery (Beland 1970, p. 759).
4. Encourage active body movement and turning-- improves the circulation, prevents venous stasis, and improves respiratory function (Moidel, et al. 1971, p. 460).
5. Provide a communication method for requesting an analgesic for discomfort--personalization and modification of care are important to the patient's well-being (Beland 1970, p. 756).
6. Teach self-help tactics when or if nauseated-- produces less dependency and more self-care; and lessens chances of aspiration of any vomitus (Beland 1970, p. 761).
7. Inform of possible shaving of operative site and reason for procedure--minimizes the possibility of wound infection from surface bacteria (Moidel et al. 1971, p. 462).

8. Inform if enema has been ordered--lessens trauma of the unknown and better prepares the patient psychologically and physiologically (LeMaitre and Finnegan 1970, p. 72).

9. Caution about nothing by mouth after midnight--this action prevents gastric contents from being vomited and aspirated during anesthesia, surgery, or postoperatively (Moidel et al. 1971, p. 464).

10. Explain about taking an early morning bath prior to preanesthesia medication and before going to surgery--both the skin and mucous membranes contain bacteria on their surfaces (Beland 1970, p. 765).

11. Remove hairpins, jewelry, wig, glasses, false teeth, and underwear--personal articles may become lost or misplaced (Moidel et al. 1971, p. 464).

12. Instruct to urinate early in the morning--an empty bladder is less likely to get punctured during surgery (Moidel et al. 1971, p. 465).

13. Administer preanesthesia medication--this will reduce anxiety, diminish secretions, and promote drowsiness (Moidel et al. 1971, p. 465).

14. Inform the patient that he will be put to sleep in the operating room. Misconceptions concerning



preanesthesia medication producing total sleep will be dispersed (LeMaitre and Finnegan 1970, p. 59).

15. Inform that the recovery room period will vary according to the individual patient. The patient's psychological and physiological status will influence his recovery room stay (Beland 1970, p. 773).

16. Inform where the waiting room is located and who will notify the patient's family when the operation is over. The patient's family is significant and supports the patient (Moidel et al. 1971, p. 459).

### Summary

Communication is socialization on many levels. It involves the use of language and cultural considerations in frequent interpersonal situations. Through the use of imagination and planning, the nurse uses verbal communication to dispel the fears and fallacies of the monolingual Spanish-speaking patient. Within the hospital setting, the nurse is provided with frequent exposure to ethnic patients and their cultural views. Of special interest is the nurse-patient interaction in a presurgical situation: the delivery of preoperative care. The presurgical patient is anxious, afraid, and may not speak any English. When communication barriers are present, the nurse's recognition and applied positive action surmounts them. The patient

also helps in bridging the barriers; once he recognizes the nurse's genuine interest to help, he, too, assumes an active role.

## CHAPTER III

### METHODOLOGY

A descriptive design was decided upon as the approach utilized to gather the research data. The study made no judgments, no evaluations, and no statements of quality; it solely described the outcome of the collected data (Fox 1966, p. 31). The study was conducted with the phonetic bilingual preoperative instruction guide as the principal research instrument.

#### Authorization

Prior to introducing the study to the participating monolingual Spanish-speaking subjects, the proposed research, involving humans, was submitted to the Human Research Review Committee for approval (Appendix A). This authorization was required since the study involved the use of human participants whose rights must not be infringed (Travers 1969, p. 80). On January 28, 1975, the Human Research Review Committee reviewed and approved the investigator's protocol (Appendix B).

Setting

The setting for the pilot study was conducted in hospitals in the Dallas, Texas area where monolingual Spanish-speaking presurgical patients are admitted. At the time the pilot study was conducted, it was found that the admissions of persons who met the criteria for the study were few and infrequent. Therefore, in order to obtain a target population large enough to collect sufficient data, the setting of the major study was the home environment of healthy monolingual Spanish-speaking persons. These subjects assumed the role of the presurgical patient in order that the Bilingual Phonetic Preoperative Instruction Guide could be tested.

The setting for the collection of data for the major study took place in the Dallas, Texas community areas where Spanish-speaking persons resided. The investigator went to predominately Spanish-speaking neighborhoods, and on a door-to-door approach, obtained consenting non-English-speaking healthy participants (Appendix C). An appointment was set up convenient to the participant, and a brief interview for obtaining biographical data was held (Appendix D).

Population

A total of thirty primarily non-English-speaking persons participated in this study. All subjects were healthy, consenting adults.

The student nurse participants, selected from baccalaureate nursing programs, were also thirty in number. All student nurses were asked to participate on a voluntary basis. The major screening factor required of the student nurse was whether or not he or she spoke the Spanish language. Any student nurse who spoke fluent Spanish was disqualified. The purpose of using the bilingual Spanish phonetic tool was to provide communication between the non-Spanish-speaking nurse and the monolingual Spanish-speaking person.

The investigator attended junior and senior nursing classes and requested volunteers to participate in the study. All the student nurses received the following information to elicit their cooperation. The bilingual phonetic guide would:

1. Provide a simplified form of giving basic preoperative instructions to monolingual Spanish-speaking patients.
2. Promote more nurse-patient involvement toward health care.

3. Aid in decreasing the presurgical patient's and the nurse's anxiety due to their inability to communicate with each other.

The following information was also included concerning the study:

1. The study would take place in the monolingual Spanish-speaking person's home.

2. The Spanish-speaking person would be of a well-level health status.

3. Each student nurse and Spanish-speaking person would participate in the study one time only.

4. The study would take place at a time and date that was agreeable to both the Spanish-speaking person and the student nurse.

5. Prior to instructing the Spanish-speaking person, the student nurse would read through the Bilingual Phonetic Guide information at least one time.

6. The student nurse would be accompanied by the investigator, in a strict nonparticipating role, during the actual delivery of the preoperative instructions.

7. Following the delivery of preoperative instructions, and after leaving the testing room, the student nurse would be given a nine-item questionnaire concerning the use of the guide.

Following actual collection of data, each participating student nurse received a letter of acknowledgement and gratitude for taking time from busy schedules to assist in this study (Appendix E).

### Description of Instruments

#### Bilingual Preoperative Instruction Guide

An instrument tailored to accommodate this particular type of study had not been devised, therefore, certain steps were necessary. The investigator developed a list of basic preoperative instructions from recognized texts (Beland 1970, pp. 759-773; Moidel et al., 1971, pp. 458-465; LeMaitre and Finnegan 1970, pp. 59-72) and translated them into Spanish. The basic English preoperative instructions were accompanied by the phonetic guide to assist in the actual pronunciation of the translated Spanish words. The original draft of the bilingual preoperative instruction guide contained thirty-nine preoperative instructions. Following the composition and development of the instruction guide, it was presented to the panel of judges for their opinion of its clarity, wording, and overall physical appearance.

The bilingual preoperative instruction guide, and the questionnaire utilized for this study were submitted to a panel of four judges. The purpose of this panel was to

consult and advise on determining the necessary factors that were essential for determining validity and appropriateness of the instruments.

The first panel judge, Dr. Arthur Babic, was a member of the Instructions Communication Department at Southwestern Medical School, Dallas, Texas. His qualifications are in the field of instruction, communication, and validation of research tests. The second member of the panel was Mrs. Christina Frias, a clinical specialist with a Master of Science degree, employed at Veteran's Administration Hospital in Dallas, Texas. In addition to being knowledgeable in Gerontology, her expertise includes preoperative and follow-up postoperative teaching to surgical patients. Being bilingual, she provided essential advice in the formulation of the Bilingual Phonetic Guide. The third member of the panel was Mrs. Jane DeLoach, clinical instructor at Texas Woman's University baccalaureate school of nursing. As a clinical instructor, Mrs. DeLoach's qualifications include a wide educational background in surgical nursing and teaching ability. The fourth member of the panel was Dr. Esperansa C. Garcia, an Anesthesiologist in private practice. Dr. Garcia strongly encourages nurses to give preoperative instructions to presurgical patients in her care. Being bilingual,



Dr. Garcia was able to clarify essential Spanish terminology necessary for the improvement of the Bilingual Phonetic Guide.

At the initial presentation of the bilingual preoperative instruction guide, the panel considered the guide to be cumbersome and unattractive in appearance. It was then condensed into a booklet. Another area of criticism was the absence of accent marks and additional instructions on the proper use of the bilingual guide. Following the investigator's consultation with Dr. Samuel A. Zimmerman, Chairman of the Spanish language department at Southern Methodist University, Dallas, Texas, the final draft to be used in the pilot study was presented and approved by the panel (Appendix F).

#### Questionnaire

The second instrument essential to the study was a questionnaire directed to the participating student nurses. In the Review of Literature, little material was available that could serve as a tool appropriate to follow the instruction guide. The questionnaire was, therefore, designed especially for this study with the following developmental criteria in mind.

1. Determine the extent the student nurse had been exposed to the Spanish language.

2. Evaluate the student nurse's view of the bilingual preoperative instruction guide. The questionnaire was also designed in accordance with rules set by Hill. His rules provide guidelines of specificity toward formulating questionnaires.

1. Be brief as possible.
2. The information asked would be otherwise inaccessible to the investigator.
3. The subject inquired about must have importance to justify the time and effort involved.
4. The wording of each item should be understandable and familiar.
5. Items should be arranged in a neat, logical order.
6. The questionnaire should take up a minimum amount of the respondent's time.
7. The instructions must be clear as to the way the answers are to be indicated (1964, p. 202).

The primary purpose of the questionnaire was to ask specific opinions about the bilingual phonetic preoperative instruction guide. The questionnaire was divided into three parts for definite purposes. The first part of the questionnaire inquired as to the extent, if any, the student nurse had been exposed to the Spanish language. The second part contained statements used to evaluate the usefulness of the bilingual phonetic preoperative instruction guide as the student nurse perceived it. The Likert scale was used to elicit responses. The five-graded scale, with

its construction simplicity, provided certain specific benefits to this study:

1. easy formulation of brief, concise statements to construct the questionnaire,
2. permitted the student nurse to respond in terms of a degree scale expressing agreement or disagreements to each statement, and
3. provided a criterion measure of the bilingual phonetic preoperative instruction guide (Abdellah and Levine 1965, pp. 242-243).

The third part contained two open-ended questions which elicited comments from the participating student nurse. The two questions provided the student nurse with an opportunity to give additional pros and/or cons regarding his or her reaction to the bilingual phonetic preoperative instruction guide. The finalized draft approved by the panel of judges was then tested in the pilot study (Appendix G).

#### Recording Form

A third instrument necessary to this study also had to be specifically developed. A method to record patient responses toward the instructions given through the bilingual phonetic guide was essential. The recording form concentrated on particular areas of concern:

1. To record the behavioral responses as they were performed, when they were performed, and if they were performed at all.

2. To record the verbal responses as they were elicited, when they were elicited, and if they were elicited at all.

3. To set a limit on the number of times that an instruction could be given by the student nurse to the Spanish-speaking person.

4. To record the participating Spanish-speaking person's evaluation of the method used to give the preoperative instructions.

The recording form was developed in keeping with Wandelt's (1970, p. 203) suggestion that a prescaled recording tool could be used on which the observer checks the behavioral or verbal response at the time these were made. The recording form was divided into three specific parts for better utilization.

The first part of the recording form was designed to record the Spanish-speaking person's behavioral responses. In keeping with Coelho et al. (1974, p. 181), acknowledgement has to be given to the exposure of psychological stress induced when an individual performs something new and unfamiliar. The investigator had two areas of concern:

1. The monolingual English-speaking student nurse, delivering preoperative instructions in Spanish

phonetics, a language unfamiliar and different in its pronunciation.

2. The monolingual Spanish-speaking person, who would receive, try to understand, and perform the phonetic preoperative instructions.

Coelhol et al. (1974, p. 183) further contends that an individual's level of performance would gradually diminish with the continued pressure to perform. It was advised by Dr. Babick, an expert in the area of research test validation, to establish a limit on the times an instruction could be given. It was decided that three would be the limit that a preoperative instruction could be given before the student nurse would stop and go on to the next preoperative instruction. The criteria set for repetition of the behavioral instructions was based on the Spanish-speaking person's returned demonstration. If the desired performance had not been initially demonstrated by the Spanish-speaking person, the student nurse was instructed to repeat the instruction. The Spanish-speaking person was instructed that if he was unable to understand an instruction by the third time, not to become unduly distressed. He was advised to be patient, listen to the next instruction, and try to comprehend it. An X marked

each specific behavioral response on a scale of performance demonstrated. The first, second, or third time, or not at all.

The second part of the recording form concentrated on the preoperative instructions that could not be elicited through behavioral demonstration. This area contained ten short leading questions which permitted minimal verbal responses from the participating Spanish-speaking person. The verbal responses were recorded on the same principle as the behavioral responses: elicited on the first, second, or third time, or not at all.

The third part contained three questions that could be answered with a yes or no response by the Spanish-speaking person. These questions were formulated to elicit the individual's reaction to the bilingual phonetic preoperative instruction guide (Appendix H).

#### Description of the Pilot Study

The pilot study was conducted to test the wording of the bilingual phonetic guide and to insure that the questionnaire and evaluation forms were precise and relevant (Abdellah and Levine 1965, p. 706; Treece and Treece 1973, p. 90). The pilot study was conducted in a hospital setting with presurgical monolingual Spanish-speaking patients. Four student nurses and four presurgical

patients comprised the sample. The sample size was decided upon by criteria in accordance with Treece and Treece (1973, p. 90). It had to include enough people to reveal any problems inherent in the instruments.

Description of Data Collection  
for the Pilot Study

On the afternoon of the day before his surgery took place, the monolingual Spanish-speaking presurgical patient was contacted. Following verification that the patient was indeed monolingual in the Spanish language, he was interviewed, and the purpose of the visit explained. Once the patient signed the consent form to participate in the study, the investigator left, to return that same evening with the participating student nurse.

The student nurse introduced herself to the patient through the use of the bilingual phonetic preoperative instruction guide. She then proceeded to read the phonetic instructions to the patient while the investigator stood away from them as a nonparticipating observer (Good and Scates 1954, p. 649). Prior to the beginning of the study, the patient and the student nurse were both informed that the investigator would remain silent and merely observe the patient-student nurse reaction.

Treece and Treece (1973, pp. 147-148) consider the placing of an investigator in the periphery of a clinical setting, as a non-participating observer, as lurking. They go on to say that lurking could become meddlesome or introduce observer bias. This information was taken into consideration.

The non-participating observer remained completely silent and checked the patient's behavioral responses as he or she performed each exercise. When the student nurse finished reading the preoperative instructions and had left the room, she was given the questionnaire to answer. While the student nurse was completing the questionnaire, the final steps of the study were undertaken in the patient's room. Through the aid of the prepared recording form, the patient's verbal responses were scored.

#### Pilot Study Results

The pilot study results provided essential information in regards to the need for necessary clarification of some unclear, rough areas in the instruments. Minor revisions were made in the bilingual preoperative guide. An instruction was reworded to make it more clear for the participating patient. Following the rewording, the instruction was retested on five Spanish-speaking patients.



All five patients clearly understood and performed the preoperative exercise instructions in the revised form. Another area that required revision was the recording form. A question was revised, making it more clear and better understood by the Spanish-speaking participants. Final tools are in Appendix F and H.

#### Description of the Major Study

The major study was conducted in the Spanish-speaking communities of Dallas, Texas. Spanish-speaking, healthy individuals were located on a door-to-door approach, and willing participants were thus obtained for the study. Following receipt of written consent to participate and biographical data, a convenient time for the student nurse and the Spanish-speaking participant was arranged.

The student nurses and the Spanish-speaking people totaled thirty each in number--one student nurse for one Spanish-speaking person for each test appointment.

#### Description of Data Collection for the Major Study

On the appointed day and time, the investigator and the student nurse met together to prepare for the testing of the bilingual phonetic guide. The student nurse was rebriefed on the facts that the participating Spanish-speaking person was monolingual and healthy. The testing

would take place in the Spanish-speaking person's home. The investigator would be in the room, in a non-participating role, while the testing was taking place. The investigator would remain silent until the student nurse finished reading the guide and exited from the testing room.

The student nurse was given the bilingual phonetic guide with instructions to read through the booklet at least once. Directions on how to pronounce phonetically the Spanish-sounding words were provided in the guide.

Together, the investigator and the student nurse went to the Spanish-speaking person's home for the appointed testing. The student nurse sat in a chair facing the Spanish-speaking person, who sat on a bed or a sofa. For the purpose of the preoperative instructions concerned with lying down and sitting up, a place to allow the person to perform these exercises was essential. The investigator stood away from the participants to observe and record the Spanish-speaking person's behavioral responses to the preoperative instructions.

When the student nurse was finished reading the preoperative instructions and had exited from the testing room to answer the nine-item questionnaire, the last part of the testing was carried out. The Spanish-speaking person

was asked short, leading questions to elicit reactions to the verbal instructions given by the student nurse.

#### Procedure for Treatment and Analysis of Data

For the purpose of this particular study, frequency distributions were utilized to facilitate interpretation of the scores. Tables were constructed to allow detection at a glance of the general distribution of the scores taken from (1) biographical data on the Spanish-speaking person, (2) the recording form, and (3) the student-nurse questionnaire. The volunteered information in Part I of the student-nurse questionnaire concerning any experience and/or exposure to the Spanish language is discussed.

#### Summary

This descriptive study was concerned with the effectiveness of the bilingual phonetic preoperative instruction guide as utilized by the monolingual English-speaking nurse for the monolingual Spanish-speaking person. The study took place in Spanish-speaking communities, in the Spanish-speaking person's home. The participating student-nurse population did not speak fluent Spanish, though thirteen of the thirty students had been exposed to some degree to the Spanish language.

The bilingual phonetic preoperative instruction guide, the student-nurse questionnaire, and the recording form were the principal tools for the collection of data. Frequency distributions were utilized to determine various aspects of the collected data extracted from the Spanish-speaking participants and the student-nurse population. The results of the analyzed data appear in Chapter IV of this study.

## CHAPTER IV

### ANALYSIS OF DATA

This descriptive study was concerned with the bilingual phonetic preoperative instruction guide and its degree of effectiveness in providing communication between the monolingual English-speaking nurse and the monolingual Spanish-speaking person. A convenience sample of thirty arbitrarily selected Spanish-speaking persons and thirty student nurses were involved in the study population.

Specified areas comprised the analyzed data:

(1) the questionnaire utilized by the student nurse, (2) the recording form utilized for observation and questioning the Spanish-speaking person, and (3) the biographical data collected on each participating Spanish-speaking person. A summary of the findings conclude the chapter.

#### Description of the Sample

Table 1 contains information about the Spanish-speaking subjects with regard to age, sex, marital status, length of time in the United States, where the individual received his school education, level of education, occupation, and previous experience with hospitalization and surgery.

**TABLE 1**  
**BIOGRAPHICAL DATA OBTAINED FROM SPANISH-SPEAKING**  
**PERSONS IN THE STUDY GROUP**

Subject	Age	Sex	Marital Status	Years Lived in U.S.A.	Country Where Educated	Educational Level*	Occupation	Hospital Experience	Surgical Experience
1	56	Female	Married	2		1	Housewife	Yes	No
2	21	Female	Married	2	Mexico	4	Housewife	Yes	Yes (2) **
3	42	Female	Married	2	Mexico	2	Housewife	Yes	Yes (1) **
4	24	Female	Married	5	Mexico	2	Housewife	Yes	No
5	26	Female	Married	3	Mexico	2	Housewife	Yes	No
6	27	Female	Married	3	Mexico	2	Housewife	Yes	Yes (1) **
7	40	Female	Married	2	Mexico	2	Housewife	Yes	Yes (1) **
8	28	Female	Married	1	Mexico	2	Housewife	No	No
9	60	Female	Married	57		1	Housewife	Yes	Yes (2) **
10	43	Female	Married	26	Mexico	2	Housewife	Yes	No
11	25	Female	Married	7	Mexico	2	Seamstress	No	No
12	72	Female	Widow	72	U.S.A.	2	Housewife	Yes	Yes (2) **
13	32	Female	Married	3	Mexico	2	Housewife	Yes	No
14	25	Female	Married	8	Mexico	2	Housewife	No	No
15	48	Female	Married	5	Mexico	2	Housewife	Yes	Yes (1) **
16	46	Male	Married	20	Mexico	2	Unemployed	No	No
17	28	Female	Married	1	Mexico	2	Housewife	No	No
18	20	Female	Married	9	Mexico	2	Housewife	No	No
19	43	Female	Married	.04	Mexico	2	Housewife	No	No
20	54	Female	Married	54		1	Housewife	No	No
21	30	Female	Married	1.50	Mexico	2	Housewife	Yes	No
22	30	Male	Married	1.50	Mexico	2	Cook	No	No
23	41	Female	Married	2	Mexico	2	Housewife	Yes	No
24	63	Female	Married	26	Mexico	2	Housewife	Yes	Yes (7) **
25	55	Female	Married	.33		1	Housewife	No	No
26	31	Female	Married	6	Mexico	2	Housewife	Yes	Yes (1) **
27	48	Male	Married	2		1	Odd jobs	No	No
28	20	Female	Single	.17	Mexico	3	None	No	No
29	23	Female	Married	.42	Mexico	2	Housewife	Yes	No
30	25	Female	Married	2.50	Mexico	2	Housewife	Yes	Yes (1) **
							Totals Yes =	18	10
							No =	12	20
N = 30									

\*1=no education, 2=grade school, 3=high school, 4=vocational 5=other.

\*\*yes (and number of times operated).

Ninety percent of the Spanish-speaking subjects were female, 10 percent were male. This is a result of more female subjects being available at home in the daytime. Of the females, 83.3 percent were housewives. From the 10 percent males who participated in the study, 3.3 percent were unemployed.

The age range of the participating subjects varied. Forty percent (12) of the subjects were between twenty and thirty years of age, 13.3 percent (4) of the subjects were between thirty to forty years of age, 26.7 percent (8) were from forty to fifty years of age, 10 percent (3) were from fifty to sixty years of age, and 10 percent (3) were from sixty to seventy-two years old. The majority of participating subjects ranged between twenty and thirty years of age; it was not assumed that the study subjects were representative of the total Spanish-speaking population.

Eighty percent (24) of the subjects received their formal education in Mexico, 3.3 percent (1) were educated in the United States, and 16.7 percent (5) never attended school.

The length of time the Spanish-speaking subjects had lived in the United States ranged from two weeks to seventy-two years. The individuals who had lived in the United States from two years to nine years represented

53.3 percent (16), but it could not be assumed that the study subjects were representative of the Spanish-speaking population.

With consideration to previous experience with hospitalization and surgery, 60 percent (18) of the tested subjects had been hospitalized. From the 60 percent of subjects who admitted to being hospitalized, 33.3 percent (10) had undergone some type of surgical procedure. Previous surgical experience varied; 20 percent (6) of the subjects had been operated on once, 10 percent (3) had been operated on twice, and 3.3 percent (1) had experienced surgical procedures seven different times, with the year 1971 being the most recent time an operation had taken place.

Table 2 is a list of the information about the student-nurse participants, according to age, sex, educational level, nursing school, and previous experience and/or exposure to the Spanish language. This information was gathered from the first portion of the student-nurse questionnaire. The student-nurse population consisted of twenty-nine females and one male. There were sixteen juniors and fourteen seniors.

Information pertaining to the question, "Any previous experience with/or exposure to the Spanish language?" resulted in the following answers: seventeen



TABLE 2

DISTRIBUTION OF STUDENT-NURSE PARTICIPANTS ACCORDING  
TO AGE, SEX, EDUCATIONAL LEVEL, NURSING SCHOOL,  
AND PREVIOUS EXPERIENCE WITH/OR EXPOSURE  
TO THE SPANISH LANGUAGE

Subject	Age	Sex	Educational Level	Nursing School	Previous Experience with/ or Exposure to the Spanish Language
1	22	F	Senior	T.W.U.	No
2	23	F	Senior	T.W.U.	No
3	22	F	Junior	T.W.U.	No
4	22	F	Junior	T.W.U.	Yes
5	21	F	Junior	T.W.U.	Yes
6	20	F	Junior	T.W.U.	No
7	21	F	Senior	T.W.U.	Yes
8	21	F	Junior	T.W.U.	No
9	20	F	Junior	T.W.U.	Yes
10	20	F	Junior	T.W.U.	No
11	20	F	Junior	T.W.U.	No
12	21	F	Senior	T.W.U.	No
13	20	F	Junior	T.W.U.	No
14	23	F	Junior	T.W.U.	No
15	23	F	Junior	T.W.U.	No
16	21	F	Junior	T.W.U.	No
17	21	F	Junior	T.W.U.	Yes
18	22	F	Senior	T.W.U.	Yes
19	21	F	Senior	T.W.U.	Yes
20	21	F	Senior	T.W.U.	No
21	21	F	Junior	T.W.U.	Yes
22	20	F	Junior	T.W.U.	Yes
23	21	F	Senior	T.W.U.	Yes
24	21	F	Senior	T.W.U.	Yes
25	23	F	Senior	T.W.U.	Yes
26	21	F	Senior	B.U.	No
27	20	F	Junior	T.W.U.	Yes
28	21	F	Senior	T.W.U.	No
29	29	M	Senior	T.W.U.	No
30	22	F	Senior	T.W.U.	No

N = 30

Totals Yes = 13

No = 17

students answered "no," and thirteen students answered "yes." Of the thirteen, two student nurses had lived in predominately Spanish-speaking surroundings. They had heard the Spanish language spoken, but admitted to the inability to speak the language.

Three student nurses had worked in hospitals where they had had contact with Spanish-speaking patients. The first student had used a Spanish-English dictionary to communicate with her patients. The second student had used "some" Spanish words in the labor and delivery room to communicate with pregnant patients. The third student had heard Spanish spoken in a hospital.

The remaining eight student nurses were exposed to Spanish in a classroom setting. One student had taken three months of Spanish medical terminology. Three students had taken one year of high school Spanish, three other students had had two years, and one student had taken four years.

Although all thirteen student nurses had been exposed to the Spanish language in one way or another, the stipulation concerned with speaking Spanish was emphasized. They could participate in the study only if their verbal usage of Spanish was limited. All thirteen students agreed they were unable to speak Spanish. They asserted to not

having practiced or used the language after studying it in high school. Pohl confirms that if "you have not spoken, read, or listened to that tongue since the day you stopped studying it, you are well aware of how lack of use can weaken or even extinguish a habit" (1974, p. 23).

### Statistical Analysis of Findings

The purpose of this study was to develop a tool to set up basic communication between the monolingual Spanish-speaking person and the monolingual English-speaking nurse, and to determine if the phonetic preoperative instruction guide provided effective communication.

### Recording Form

For the purpose of determining to what extent effective communication had taken place, certain questions and responses were used to gauge when and if the Spanish-speaking subject would act out a preoperative exercise as instructed by the student. Ten verbal responses were employed to record the subject's recall to preoperative instructions that could not be visually observed. An addition of three verbal questions was also applied. These questions were to obtain feedback from the Spanish-speaking subject concerning the bilingual preoperative instruction guide and the student nurse who used it.

Table 3 summarizes the frequency of responses to each of the eight behavior instructions. Also tabulated is each behavioral response in the order that each of the eight behavior instructions were performed most frequently--the first time, the second time, the third time, or not at all.

Behavior instruction 1, "Breathe deeply," was most frequently responded to correctly on the first time by 83.3 percent (25) of the Spanish-speaking subjects; 3.3 percent (1) did not respond at all. One subject stated she understood all eight behavior instructions but felt too self-conscious to perform them. This same individual, when tested on the verbal responses, was able to recall all the instructions given by the student with the exception of the one on smoking.

As can be noted in Table 3, behavior instruction 1 was not followed immediately in frequency of correct performance by behavior instruction 2. Sixty percent (18) of the subjects responded correctly on the first time to behavior instruction 2, "to cough." In contrast, 83.3 percent (25) responded correctly on the first time to behavior instruction 6, to sit up in bed.

Behavior instruction 8, say the word "pain," tabulated noteworthy percentages and comments. Fifty

TABLE 3

## NUMBER OF ATTEMPTS NECESSARY FOR CORRECT BEHAVIORAL RESPONSES

Behavior Instruction	Responded to Instruction				Total Subjects
	First Time	Second Time	Third Time	Not at All	
1. Breathe deeply	25 (83.3%)	3 (10.0%)	1 ( 3.3%)	1 ( 3.3%)	30
6. Sit up in bed	25 (83.3%)	2 ( 6.7%)	0	3 (10.0%)	30
4. Bend knees	24 (80.0%)	4 (13.3%)	0	2 ( 6.7%)	30
7. Lie down in bed	23 (76.7%)	2 ( 6.7%)	0	5 (16.7%)	30
3. Lie on one side	23 (76.7%)	4 (13.3%)	1 ( 3.3%)	3 (10.0%)	30
5. Straighten legs	20 (66.7%)	6 (20.0%)	2 ( 6.7%)	2 ( 6.7%)	30
2. Cough	18 (60.0%)	3 (10.0%)	3 (10.0%)	6 (20.0%)	30
8. Say the word "pain"	15 (50.0%)	5 (16.7%)	2 ( 6.7%)	8 (26.7%)	30

percent (15) of the Spanish-speaking participants attempted and correctly responded to the instruction; 16.7 percent (5) answered correctly the second time the instruction was repeated, and 6.7 percent (2) were able to pronounce the word "pain" on the third try, 26.7 percent (8) did not say the word "pain" on the third try, 26.7 percent (8) did not say the word "pain" at all. Some of the 26.7 percent (8) participants nodded to the student nurse indicating that the instruction was clear, but still declined to verbalize the word. When questioned later concerning the decline, some declared the word "pain" sounded "funny" to pronounce, to others it sounded "different," or "odd."

Looking at the behavioral responses in an overall manner, 70 percent of the Spanish-speaking participants responded correctly to all the behavioral instructions the first time they were given. Twelve percent of the participants responded to some of the behavior instructions correctly the second time each was given. Three percent of the participants responded to some of the behavior instructions correctly the third time each was given. Twelve percent did not respond at all to some of the instructions.

From the 12 percent who did not respond at all to some of the behavior instructions, some observations

concerning their immediate testing environment were noted. The collection of data took place in each Spanish-speaking person's home. The testing area was subject to uncontrolled distractions and interruptions. The preliminary instruction given each participant prior to testing was: supply a room with a bed or sofa; free of noise, interruptions; and of anyone else, aside from the participant, the student nurse, and the investigator. In several cases, although the participant's children were in another room away from the testing area, their playing and loud voices could be heard. In other cases a small child would cry and time was taken to pacify him. On two separate testings, the participant's small child insisted on coming in the room to be near his mother. Although in each instance the child remained silent, the participants appeared self-conscious or distracted when asked to do an exercise.

Table 4 tabulates the frequency of responses to each verbal instruction. Each verbal response is given in the order that each of the ten verbal instructions were answered correctly, the first time, the second time, the third time, or not at all. It can be noted that the questions most frequently answered correctly the first time did not necessarily follow their numerical sequence. Also, the participant was not required to give verbatim answers

TABLE 4

## NUMBER OF ATTEMPTS NECESSARY FOR CORRECT VERBAL RESPONSES

Question	Responded to Question with Correct Answer			
	First Time	Second Time	Third Time	Not At All
10. During an operation, your family waits in the waiting room on this floor. Who notifies your family when the operation is over?	29 (96.7%)	1 ( 3.3%)	0	0
6. Before an operation, you remove hairpins, jewelry, wig, glasses, false teeth, underwear, and give them to whom?	28 (93.3%)	2 ( 6.7%)	0	0
7. You will receive an injection about one hour before the operation. What will the injection do to you?	27 (90.0%)	0	1 (3.3%)	2 ( 6.7%)
1. When are you to do your exercises?	26 (86.7%)	4 (13.3%)	0	0
9. After an operation, when will you be returned to your room?	26 (86.7%)	3 (10.0%)	0	1 ( 3.3%)
3. What should you do if you become nauseated?	26 (86.7%)	4 (13.3%)	0	3 (10.0%)



TABLE 4 (Continued)

Question	Responded to Question with Correct Answer			
	First Time	Second Time	Third Time	Not At All
5. Before an operation, what time of the night are you not to eat or drink anything?	23 (76.7%)	2 ( 6.7%)	2 (6.7%)	3 (10.0%)
2. If you smoke, why should you try not to smoke before an operation?	22 (73.3%)	3 (10.0%)	0	5 (16.7%)
4. Why is the area to be operated on shaved?	21 (70.0%)	9 (30.0%)	0	0
8. In the morning, you are to urinate before going to the operating room, and before receiving what type of medication?	16 (53.3%)	7 (23.3%)	0	7 (23.3%)

to the questions. The answer did have to correspond with the question.

Question 8, "In the morning you are to urinate before going to the operating room, and before receiving what type of medication?" was answered correctly by 53.3 percent (16) the first time and 23.3 percent (7) when asked the question a second time. This question also received the highest percentage, 23.3 percent (7) of participants who did not answer correctly at all.

The second highest percentage of not answering correctly at all was associated with Question 2, "If you smoke, why should you try not to smoke before an operation?" The answer, regarding less smoking promoting cleaner lungs, could not be recalled by 16.7 percent (5) of the participants. Upon further questioning of the 16.7 percent concerning smoking, all the participants declared they did not smoke; therefore, the instruction was forgotten. These participants all stated they did not recall the instruction since it did not apply to them.

Looking at the verbal responses overall, 80.3 percent responded to some verbal instructions the first time, 11.7 percent responded with the correct answer the second time, 1 percent responded correctly the third time, and 7 percent were unable to recall an answer to some of the questions.

For both the behavioral and verbal responses, the Spanish-speaking person's understanding of preoperative instructions from the phonetic guide was excellent. Together, the behavior and verbal responses were answered correctly on the first, second, and third time by a total of 90.5 percent of the Spanish-speaking participants. In contrast, 9.5 percent of the participants did not respond at all to some of the behavior and verbal instructions. Some degree of communication was established in every testing situation.

The third part of the recording form consisted of three questions directed to the Spanish-speaking participant. These questions related to the participant's view of (1) the bilingual phonetic preoperative instruction guide, and (2) the manner in which the student nurse utilized it. The questions were answered with "yes" or "no." All the participants answered "yes" to all three questions listed:

11. Were you able to understand the information the nurse read to you with the guide?

12. Did the information tell you what you need to know before an operation?

13. Did you like the way the nurse, who speaks no Spanish, gave the information concerning an operation?

### Student-Nurse Questionnaire

Following the completion of reading the bilingual phonetic preoperative instructions to the Spanish-speaking participant, the student nurse exited from the testing area. She or he then proceeded to complete the questionnaire.

The first portion of the questionnaire, asking for a small amount of biographical information is recorded in Table 2. The questionnaire contained seven statements directed toward discerning the student nurse's view of the bilingual phonetic guide and its use. These statements were placed on a five-degree Likert scale. Two open-ended questions comprised the last part of the questionnaire. These two questions provided the student nurse with the opportunity to elaborate on the good or bad aspects concerning the guide.

Table 5 provides the overall results taken from the student-nurse questionnaire. Each statement was recorded in the order most often selected by the student nurse. All the student nurses agreed that the guide helped in actively involving the "patient" with the preoperative exercises, with 50 percent strongly agreeing and 56.7 percent agreeing.

TABLE 5

## RANKING OF SCORES TAKEN FROM THE STUDENT-NURSE QUESTIONNAIRE

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
6. The guide was useful in giving preoperative instructions for preoperative care.	19 (63.3%)	11 (36.7%)	0	0	0
7. The manner in which the instructions were presented in the Instruction Guide was simple to use.	18 (60.0%)	11 (36.7%)	0	1 (3.3%)	0
1. The guide helped in actively involving the "patient" with the preoperative exercises.	16 (53.3%)	14 (46.7%)	0	0	0
4. The "patient" responded appropriately to specific instructions.	13 (43.3%)	14 (46.7%)	0	3 (10.0%)	0
2. The language barrier between the nurse and the "patient" was narrowed through the use of the guide.	12 (40.0%)	17 (56.7%)	1 (3.3%)	0	0

TABLE 5 (Continued)

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
3. The Spanish phonetic words were simple to pronounce to the "presurgical patient."	6 (20.0%)	18 (60.0%)	5 (16.7%)	1 ( 3.3%)	0
5. Instructing the "presurgical patient" with the guide was a comfortable experience.	1 ( 3.3%)	15 (50.0%)	10 (33.5%)	4 (13.3%)	0

With statement 2, the language barrier between the nurse and the "patient" was narrowed through the use of the guide, 96.7 percent (29) agreed and 3.3 percent (1) neither agreed nor disagreed. For statement 3, the Spanish phonetic words were simple to pronounce to the "presurgical patient," 20 percent (6) of the students strongly agreed, 60 percent (18) agreed, 16.7 percent (5) neither agreed nor disagreed, and 3.3 percent (1) disagreed.

Statement 4, the "patient" responded appropriately to specific instructions, was answered in the following manner: 43.3 percent (13) strongly agreed, 46.7 percent (14) agreed, and 10 percent (3) disagreed. The answers to statement 5, instructing the "presurgical patient" with the guide was a comfortable experience, were noteworthy: 3.3 percent (1) strongly agreed, 50 percent (15) agreed, 33.3 percent (10) neither agreed nor disagreed, and 13.3 percent (4) disagreed. Upon further inquiry, the 13.3 percent who disagreed declared feeling (1) uncomfortable in a situation where they were not in complete control, and (2) anxious when speaking in a foreign language that sounded alien from their own.

All the student-nurse population agreed with statement 6. The guide was useful in giving preoperative instructions for preoperative care. To be more specific,

63.3 percent (19) strongly agreed and 36.7 percent (11) agreed. Even when 13.3 percent (4) disagreed with statement 5 and felt that instructing the "presurgical patient" with the guide was an uncomfortable experience, they agreed that the guide was useful in giving preoperative instructions.

Statement 7, the manner in which the instructions were presented in the instrument guide was simple to use, immediately followed Statement 6 in sequence. Sixty percent (18) strongly agreed, 36.7 percent (11) agreed, and 3.3 percent (1) disagreed. This indicated that when the student nurse answered the sixth statement in a positive manner, the seventh statement was also answered positively.

The seven-item questionnaire received an overall response from the students: 40.5 percent strongly agreed with all seven statements and 47.6 percent agreed. Statement 2, the language barrier was narrowed through the use of the guide, was neither agreed nor disagreed to by 3.3 percent. Statement 3, the Spanish phonetic words were simple to pronounce, was neither agreed nor disagreed to by 16.7 percent. Statement 5, instructing the "presurgical patient" with the guide was a comfortable experience, was answered with 33.3 percent who neither agreed nor disagreed. This



total represented 7.6 percent of the student nurses who neither agreed nor disagreed.

An overall total of 4.3 percent of the students disagreed with certain items in the questionnaire: 3.3 percent disagreed with statement 7, the manner in which the instructions were presented in the guide was simple to use. Ten percent disagreed with statement 4, the "patient" responded appropriately to specific instructions. Statement 3, the Spanish phonetic words were simple to pronounce to the "presurgical patient" was disagreed with by 3.3 percent. The highest percentage to disagree was 13.3 percent with statement 5, instructing the "presurgical patient" with the guide was a comfortable experience.

The last portion of the student nurse questionnaire pertained to two open-ended questions aimed at the bilingual phonetic guide:

1. What aspect of the guide was most helpful to you?
2. What aspect of the guide was least helpful to you?

According to the student-nurse participants, the guide was most helpful in varying ways. Fifty percent (15) named the phonetics as being the most helpful part of the guide. The pronunciation instructions at the

beginning of the guide were identified by 26.7 percent (8) as being most helpful. The English translations found throughout the guide were considered most helpful by 23.3 percent (7) of the students. Ten percent (3) declared the ability to communicate with the Spanish-speaking person through the guide, most helpful. When the Spanish-speaking person understood and performed the preoperative exercises, 6.7 percent (2) thought this the most helpful part of the guide. The entire guide was considered most helpful to 3.3 percent (1).

Responses to the first open-ended question totaled to thirty-six answers. In several instances more than one answer was given to the question.

The second open-ended question, "What aspect of the guide was least helpful?" was also met with varying responses. Eighty percent (24) indicated there were no aspects of the guide that were the least helpful.

Twenty percent (6) specified particular areas of the guide that were least helpful to them. The inability to ask if the patient understood an instruction was considered a least helpful aspect by 6.7 percent (2) of the students. There were 3.3 percent (1) who felt that there were no pauses indicated between instructions to alert a nurse to observe an exercise performed by the

patient. Underlined syllables, placed as a point of emphasis or accent on a word, were least helpful to 3.3 percent (1). Another 3.3 percent (1) found the phonetic pronunciations difficult to read, and the final 3.3 percent (1) felt "frustrated" with phonetic words ending in "h."

#### Summary

A descriptive study was conducted with regard to the bilingual phonetic preoperative instruction guide and its degree of effectiveness in providing communication between the monolingual English-speaking nurse and the monolingual Spanish-speaking person. Three specific instruments were employed for the collection of data: (1) the student-nurse questionnaire, (2) the recording form, (3) the biographical form used on each participating Spanish-speaking person.

The biographical data collected on each Spanish-speaking participant showed 60 percent had been hospitalized sometime in their lifetime. From the 60 percent (18) who admitted to being hospitalized, 33.3 percent (10) had experienced some type of surgical procedure.

Background information related to whether any student nurse had any previous experience with/or exposure to the Spanish language, revealed thirteen students who had.

Further inquiry into each admission revealed that these thirteen students could not speak Spanish on their own.

The recording form was utilized for the purpose of determining to what extent effective communication had taken place between the Spanish-speaking person and the student nurse. Eight behavior responses and ten verbal responses served as a guide to check the extent that communication had occurred. A total 90.5 percent of the Spanish-speaking participants were able to respond correctly to the behavior and verbal instructions as given by the student nurse. In comparison, only 9.5 percent of the participants did not respond at all to some of the behavior and verbal instructions. Communication was effective with 90.5 percent of the tested participants. This outcome supported the hypothesis that the phonetic preoperative instruction guide provides basic communication between the monolingual Spanish-speaking person and the monolingual English-speaking nurse.

Information gathered from the student-nurse questionnaire proved of interest to the study. The student was directed to give his own verdict of the bilingual phonetic preoperative instruction guide and its use. The seven-item questionnaire was placed on a five-degree Likert scale. The overall student response totaled 88.1 percent

who agreed that the guide (1) was useful in giving preoperative instructions, (2) was simple to use, (3) helped actively involve the "patient" with the preoperative exercises, (4) allowed the "patient" to respond appropriately to specific instructions, (5) narrowed the language barrier between the nurse and the "patient," (6) was simple to pronounce to the "presurgical patient," and (7) was a comfortable experience. A total of 7.6 percent represented the student nurses who neither agreed nor disagreed.

The total response of 4.3 percent of the students disagreed with certain items in the questionnaire. The majority of this percentage felt that instructing the "presurgical patient" with the guide was not a comfortable experience.

A descriptive approach was utilized in presenting the responses to the last portion of the student-nurse questionnaire, the two open-ended questions. The students all indicated various aspects of the guide were most helpful. The most helpful aspects of the guide were the phonetics, the pronunciation instructions, the English translations that accompanied each instruction, the ability to communicate with the Spanish-speaking person, and the Spanish-speaking person

understanding and performing the exercises. Some students considered the entire guide helpful.

The least helpful aspects of the guide, according to the students, were the inability to ask if the patient understood an instruction, no pauses indicated between instructions to alert the nurse to observe the patient perform an exercise, the underlined syllables placed as an accent mark on the word, and the phonetic pronunciations were difficult to read. One student expressed "frustration" with phonetic words ending in "h."

## CHAPTER V

### SUMMARY, RECOMMENDATIONS, IMPLICATIONS, AND CONCLUSIONS

#### Summary

This study was concerned with testing the effectiveness of the bilingual phonetic preoperative instruction guide. The purposes of the study were (1) to develop a tool to set up basic communication between the monolingual Spanish-speaking person and the monolingual English-speaking nurse, and (2) to determine if the phonetic preoperative instruction guide provided effective communication.

The review of literature focused on communication, language, cultural considerations, the Spanish-speaking population, patient education, and preoperative instructions. Theories, histories, and studies which gave specific support to this particular study were included.

Data were collected from (1) thirty monolingual Spanish-speaking participants selected from communities in the Dallas, Texas, area, and (2) thirty monolingual English-speaking student nurses from baccalaureate nursing schools also in the Dallas, Texas, area. Interviewing and

silent observation were the methods employed for the collection of data. Frequency distribution tables were used to exemplify the results of the data collected from the recording form, the Spanish-speaking participants' biography, and the student-nurse questionnaire. The biographical information and open-ended questions answered by the students were discussed.

Analysis of the Spanish-speaking participants indicated that their average level of education was grade school; the country where the majority were educated was Mexico. Previous hospital experience totaled to eighteen participants; ten had previous surgical experiences ranging from one to seven times.

The student nurses consisted of fourteen seniors and sixteen juniors. Thirteen of the students had previous experience with/or exposure to the Spanish language. These thirteen students ascertained they could not speak Spanish.

The behavioral and verbal responses recorded through the use of the recording form were exceptional. A total of 90.5 percent of the Spanish-speaking participants understood and correctly responded to the phonetic instructions given by the students from the guide. The guide was useful in providing basic communication between a Spanish-speaking person and an English-speaking nurse.



The third and last portion of the recording form contained three questions regarding the Spanish-speaking person's view of the bilingual phonetic guide and the student nurse who used it. The responses were all positive and could not be considered of any value. The possibility that the participant was expressing favoritism toward the investigator, who asked these three questions, could not be disregarded.

Responses, by the student nurses, to the questionnaire were noteworthy. The majority of students, 88.1 percent, agreed the bilingual phonetic preoperative instruction guide was useful in providing effective communication.

The hypothesis, the phonetic preoperative instruction guide provides basic communication between the monolingual Spanish-speaking person and the monolingual English-speaking nurse, was supported.

In regard to the open-ended questions, some of the students regarded certain areas of the guide as being least helpful. The phonetics were emphasized as being the most helpful aspect of the guide by 50 percent of the students.

### Conclusions

Based on the findings of the data collected, the following conclusions are offered:

1. The guide was understood by Spanish-speaking participants of grade-school level education.

The bilingual phonetic preoperative instruction guide was useful in providing an effective method of communication.

3. The following alteration in the format of the guide would be helpful to those who administer the guide: the addition of a question requiring an indication of understanding by the patient of each instruction given.

### Recommendations

Based on the findings of this study, the following recommendations are made. To conduct:

1. A similar study in a hospital setting with preoperative Spanish-speaking patients. The understanding that the time necessary to collect sufficient data may extend anywhere from six months to two years would need to be considered

2. A follow-up study with the same patients postoperatively to determine if they were able to retain the instructions and use them to promote their convalescence

3. A similar study, within a hospital setting, utilizing registered nurses, licensed vocational nurses, and nurse's aides to determine personnel differences, if any, when teaching basic preoperative instructions in Spanish phonetics

4. A similar study involving the preoperative patient's family member, such as the spouse, and determine if this approach would be more or less than beneficial to the patient's postoperative recovery period

5. Group teaching classes for Spanish-speaking patients prior to their surgery to determine if this approach would be more conducive for learning than individualized teaching

6. Group teaching classes for nurses to determine if a notable difference in anxiety levels occurs when each uses the guide on a presurgical patient

### Implications

The findings of this study have implications for nursing service, nursing education, and nursing research. The relationship between the patient and the nurse in each of these mentioned areas cannot be underestimated. Communication is an integral part of nursing, but it still lacks sufficient emphasis to its utmost importance.

Generally nurses have been more action-oriented and less concerned with verbal expression in relation to their work. The professional nurse, charged with the care of a non-English-speaking preoperative patient has the dual problem of planning his nursing care, plus establishing a method of verbal communication. Along with establishing a mode of communication, the nurse would need to be assigned to this same patient during the postoperative phase of his care. This would help alleviate anxiety toward an unfamiliar environment, and promote his perception in regard to preoperative teaching.

Time, effort, and concern toward providing individualized care to patients with cultural backgrounds and language different from the nurse's own should serve as an accepted challenge to the many-facet profession--nursing. All patients need encouragement to participate actively in their plan of care, to be educated, and not to stay confused indefinitely.

#### Nursing Education

The place for promoting more awareness toward the individual with cultural and language differences is in the nursing programs. Student nurses need to be frequently exposed to the various teaching and learning techniques that can facilitate communication. Emphasis needs to be

stressed that not all hospitalized patients behave and react to illness in a similar manner. The faculty should also provide opportunities for the student to care and work with monolingual Spanish-speaking patients. They should be encouraged to take time and be creative when exploring different methods of communication. Students need to be instilled in an awareness that together in providing individualized patient care, structured communication can guide patients toward understanding important aspects of their care. The patient learns to gradually be responsible for his own convalescence and rehabilitation.

A professional nurse employed in a hospital setting can also continue self-progress by seeking continuing education courses in communication. Hospitals provide continuing education through their inservice department. Physicians should be utilized and encouraged to share their knowledge toward patient education and problem-solving. Only by continually seeking, can the nurse become an instigator and promoter of new improved ideas in nursing.

#### Nursing Research

More studies to determine effective means of communicating with various culturally-attuned patients should be conducted. In the review of literature, experts agree that borrowing sounds or tones from one's own native

language to construct a foreign word is not a stable approach for learning a foreign language. This statement of fact was altered to fit the occasion--provide basic communication between a nurse and her patient. As a long-term goal, to learn Spanish, the sound substitution method may not be applicable, but only through investigative study designs will this information be provided.

Another area of major importance is establishing varying methods of conducting patient education. One primary nursing goal is to care for the individual patient; the second goal is to teach the patient to care for himself.

## APPENDIX A

## RESEARCH AND INVESTIGATION INVOLVING HUMANS

## Statement by Program Director and Approved by Department Chairman

This abbreviated form is designed for describing proposed programs in which there is justifiable minimal risk to human participants. If any member of the Human Research Review Committee should require more information, the investigator will be so notified. Six copies of this form should be submitted to the committee chairman.

Title of study: AN EVALUATION OF A BILINGUAL PREOPERATIVE  
INSTRUCTION GUIDE FOR THE MONOLINGUAL SPANISH-SPEAKING  
PATIENT.

Program Director(s): Cornelia Kenner  
Dr. Opal White  
Elizabeth Sprenger

Estimated beginning date of study: Jan. 1975 Estimated duration: March 1975

Brief description of study (use additional pages or attachments, if desired, and include the approximate number and the ages of participants):

The study involves giving preoperative instructions in phonetic Spanish to monolingual Spanish-speaking presurgical adults (ages 18 and on) admitted one day prior to their surgery. The basic preoperative instructions (coughing, deep breathing, etc.), will be given by student nurses who speak no Spanish. The student nurses will use the bilingual preoperative instruction guide with the phonetics provided. The investigator plans on gathering as many patients as are available. The goal is set at near or over forty in number.

1. What are the potential risks to the human subjects involved in this research or investigation?

None.

2. Outline the steps taken to protect the rights and welfare of the individuals involved:

1. Preservation of anonymity by using a number instead of patient's name.
2. A drawn up consent (see attached form) Whereby:
  - a. The patient consents to participate in the study
  - b. The investigator is allowed to identify the patient by the use of a number
3. After the preoperative instructions are given by the student nurse, and she leaves the room, the investigator will then clarify anything not understood by the patient.



3. Outline the method for obtaining informed consent from the subjects or from the person legally responsible for the subjects. (Attach documents, i.e., a specimen informed consent letter).

1. Investigator will give introduction speech to the patient concerning the study to be done.
2. Investigator will then, upon the patient's willingness to participate, present the consent form (see attached form) to be signed by both the patient and the investigator.

4. If the proposed study includes the administration of personality tests, inventories, or questionnaires, indicate how the subjects are given the opportunity to express their willingness to participate. If the subjects are less than the age of legal consent, or mentally incapacitated, indicate how consent of parents, guardians, or other qualified representatives will be obtained:

Does not apply to investigator's study.

(Signed) Cornelia Kemmer 11/14/75  
Program Director Date

(Signed) \_\_\_\_\_  
Dean, Department Head, or Director Date

Date received by committee chairman: \_\_\_\_\_

## APPENDIX B

TEXAS WOMAN'S UNIVERSITY  
RESEARCH INSTITUTE  
DENTON, TEXAS 76204

BONE METABOLISM LABORATORY  
Box 23546, TWU STATION  
PHONE (817) 387-5305

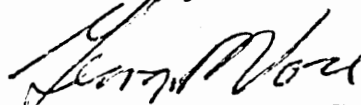
January 28, 1975

Ms. Dora Millam  
Texas Womans University College of  
Nursing  
Dallas Campus  
Dallas, Texas

Dear Ms. Millam:

The Human Research Review Committee has reviewed and approved your protocol, "An evaluation of a bilingual preoperative instruction guide for the monolingual spanish speaking patient".

Sincerely yours,



George P. Vose, Chairman  
Human Research Review Committee

## APPENDIX C

PERMISO

(Spanish Translation)

Yo, \_\_\_\_\_, doy mi permiso para  
que una enfermera me de instrucciones. Estoy asegurado  
que mi identidad no sera revelada. En lugar de mi nombre,  
usaran un numero.

Fecha \_\_\_\_\_ Firma \_\_\_\_\_  
Investigadora \_\_\_\_\_

CONSENT

(English Translation)

I, \_\_\_\_\_, give my permission for  
a nurse to give me instructions. I am assured that my  
identity will not be revealed. Instead of my name, a  
number will be used.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Investigator \_\_\_\_\_

## APPENDIX D

BIOGRAPHICAL DATA SHEET

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Length of time living in the United States \_\_\_\_\_

Received school education in  
U.S.A. \_\_\_\_\_ Mexico \_\_\_\_\_ Other \_\_\_\_\_

Type of education:

None \_\_\_\_\_  
Grade school \_\_\_\_\_  
High school \_\_\_\_\_  
Vocational school \_\_\_\_\_  
Other \_\_\_\_\_

Type of employment \_\_\_\_\_

Previous experience in a hospital? Yes \_\_\_\_\_ No \_\_\_\_\_

Had any previous surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

When? \_\_\_\_\_ How many times? \_\_\_\_\_

## APPENDIX E



Dear

I would like to express my sincere gratitude for your active participation in the testing of my thesis study: The Effectiveness of the Bilingual Phonetic Preoperative Instruction Guide. You were generous with your time and I am indeed thankful.

Sincerely,

Dora Guerra Milam, R.N.  
T.W.U. Graduate Student

DGM

## APPENDIX F

ENGLISH-SPANISH BILINGUAL PREOPERATIVE  
INSTRUCTION GUIDE

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## INSTRUCTIONS

This handbook contains Spanish phonetic translations of basic preoperative instructions. These simple, basic instructions can be verbally communicated to the Spanish-speaking patient by the non-Spanish-speaking nurse.

In the following instructions, pronounce the phonetic words provided just as you would pronounce them in your everyday English. By doing this, you will have spoken the Spanish "sound like" translation for each English word given in the preoperative instructions. The following provides additional information on pronunciation.

Before giving these instructions to the patient, go through the handbook at least one time and practice the phonetic pronunciations. Pronounce each phonetic word in a clear, slow manner, especially during the actual process of delivering these instructions to the patient.

The following information is provided to guide you in the pronunciation of the phonetics.

Pronounce:

OO	as in <u>BOOT</u>	EER	as in <u>PEER</u>
EE	as in <u>SEE</u>	ES	as in <u>ESCAPE</u>
AH	as in <u>RAH</u>	CH	as in <u>CHAIR</u>
EH	as in <u>MELLOW</u>	AR	as in <u>ART</u>
AUN	as in <u>ANONYMOUS</u>	OH	as in <u>OKAY</u>
EN	as in <u>TEN</u>	ER	as in <u>ERROR</u>

The double parallel lines || within a sentence indicate a momentary pause for the reader.

The underlined phonetic word indicates the point of emphasis within the sentence (example: MEH YAH-MOH . . .) .

INTRODUCTION:

Good	evening
BOOEN-AHS	<u>TAR-DES</u>

(buenas tardes.)

My	name is	_____.
MEH	<u>YAH-MO</u>	_____.

(me llamo)

I do not	understand	Spanish
NO	EN-TEE- <u>EN</u> -DOH	ES-PAH- <u>KNEEOL</u>

(no entiendo espanol.)

I will read	the	information	concerning
VOY AH LEH- <u>ER</u>	LAH	IN-FOR-MAH-SEE- <u>ON</u>	TOH-KAUN-TEH

preparation	for	your	operation
PREH-PAH-RAH-SEE- <u>ON</u>	PAH-RAH	SUE	OH-PERAH-SEE- <u>ON</u>

(voy a leer información tocante preparación para su operación.)

1.	Before	your	operation
	AUN-TEHS DEH	SUE	OH-PERAH-SEE- <u>ON</u>

I will teach you	exercises	that
VOY AH EN-SEH-KNEEAR-LEH	EH-HAIR- <u>SEE</u> -SEE-OHS	KEH

will help you	to get well
LEH AH-YOU-DAR- <u>AUN</u>	AH KEH SEH AH- <u>LEE</u> -VEE-eh

faster
MAS <u>PRON</u> -TOH

(antes de su operación, voy a enseñarle ejercicios que le ayudarán a que se alivie más pronto.)

2. | Do | these | exercises | in | the |  
 | AH-GAH | ES-TOHS | EH-HAIR-SEE-SEE-OHS | EN | LAH |  
 | bed |  
 | KAH-MAH |

(haga estos ejercicios en la cama.)

3. | Do | these | exercises |  
 | AH-GAH | ES-TOHS | EH-HAIR-SEE-SEE-OHS |  
 | tomorrow | after | your |  
 | MAH-KNEEAH-NAH | DES-POO-ES-DEH | SUE |  
 | operation |  
 | OH-PERAH-SEE-ON |

(haga estos ejercicios mañana después de su operación.)

4. | You | do | the | exercises |  
 | OOZE-TED | AH-GAH | LOS | EH-HAIR-SEE-SEE-OHS |  
 | first | then | I | will do them |  
 | PREE-MEH-ROH | LU-EH-GOH | YOH | LOHS AH-GOH |

(usted haga los ejercicios primero, luego yo los hago.)

### EXERCISES:

- | Now | prepare yourself | to | do |  
 | AH-ORA | PREH-PAH-REH-SEH | PAH-RAH | AH-CER |  
 | exercises |  
 | EH-HAIR-SEE-SEE-OHS |

5. | Take | a | deep | breath |  
 | TOH-MEH | OON | RES-PEE-ROH | PRO-FOON-DOH || |
 | hold it | now | let | the | air |  
 | DEH-TEN-GAH-LOH || AH-OH-RAH | DEH-HEH | EL | EYE-REH |  
 | out | slowly |  
 | SAH-LEER | DES-PAH-SEE-OH |

(tome un respiro profundo, deténgalo, ahora deje el aire salir despacio.)

6. | After | your | operation | do |  
 | DES-POO-ES DEH | SUE | OH-PERAH-SEE-ON | AH-GAH |  
 | this | exercise | ten | times |  
 | ES-TEH | EH-HAIR-SEE-SEE-OH | DEE-ES | VEH-SEHS |  
 | every | two | hours |  
 | KAH-DAH | DOHS | OH-RAHS |

(después de su operación, haga este ejercicio diez veces cada dos horas.)

7. | Now | take | a | deep | breath |  
 | AH-OH-RAH | TOH-MEH | OON | RES-PEE-ROH PRO-FOON-DOH || | |
 | then | instead | of | letting | the | air |  
 | LU-EH-GOH || EN LU-GAR | DEH | DEH-HAR | EL | EYE-REH |  
 | come out | slowly | cough |  
 | SAH-LEER | DES-PAH-SEE-OH || TOH-SAH |

(ahora, tome un respiro profundo, luego, en lugar de dejar el aire salir despacio, tosa.)

8. | Do | this | exercise | after |  
 | AH-GAH | ES-TEH | EH-HAIR-SEE-SEE-OH | DES-POO-ES DEH | |
 | each | deep | breath | every | two |  
 | KAH-DAH | RES-PEE-ROH PRO-FOON-DOH || KAH-DAH | DOHS |  
 | hours |  
 | OH-RAHS |

(haga este ejercicio después de cada respiro profundo cada dos horas.)

9. | Each | time | that you cough | be sure to |  
 | KAH-DAH | VES | KEH TOH-SAH || DEH AH-SEH-GOO ROH |  
 | spit |  
 | ES-COO-PAH |

(cada vez que tosa, de aseguro, escupa.)

[Omit #10 when inappropriate.]



10. | When | you cough | | hold | a |  
 | COO-AUN-DOH | TOH-SAH | | DEH-TEN-GAH | OONA |  
 | pillow | against | your | operation site |  
 | AL-MOO-AH-DAH | CON-TRAH | SUE | LAH-DOH OH-PERAH-DOH |  
 | the | pain | will be | minimized |  
 | EL | DOH-LOR | SEH-RAH | MINI-MOH |

(cuando tosa, detenga una almohada contra su lado operado, el dolo será mínimo.)

11. | Lie down | please | | Turn |  
 | AH-COO-ES-TEH-SEH | POR FAH-VOR | | VOL-TEH-EH-SEH |  
 | to | one | side | slowly |  
 | AH | OON | LAH-DOH | DES-PAH-SEE-OH |

(acuéstese por favor. voltéese a un lado despacio.)

12. | Change | sides | every | two | hours |  
 | KAHM-BEE-EH | DEH LAH-DOH | KAH-DAH | DOHS | OH-RAHS |

(cambie de lado cada dos horas.)

13. | Bend | your | knees |  
 | DOH-BLEH | SUES | ROH-DEE-AHS |

(doble sus rodillas.)

14. | Straighten | your | legs |  
 | EN-DEH-REH-SEH | SUES | PEE-ER-NAHS |

(enderese sus piernas.)

15. | After | your | operation | | do |  
 | DES-POO-ES DEH | SUE | OH-PERAH-SEE-ON | | AH-GAH |  
 | this | exercise | ten | times |  
 | ES-TEH | EH-HAIR-SEE-SEE-OH | DEE-ES | VEH-SEHS |  
 | every | two | hours |  
 | KAH-DAH | DOHS | OH-RAHS |

(después de su operación, haga este ejercicio diez veces cada dos horas.)

16. | When | it is time | to | sit up |  
 | COO-AUN-DOH | ES TEE-EM-POH | PAH-RAH | SEN-TAR-SEH ||
- | lie down | on your side || bend | the |  
 | AH-COO-ES-TEH-SEH | DEH LAH-DOH || DOH-BLEH | LAHS |
- | knees | slowly |  
 | ROH-DEE-AHS || DES-PAH-SEE-OH |
- | push your body away | from | the | bed |  
 | REH-TEE-REH SUE COO-ER-POH | DEH | LAH | KAH-MAH ||
- | Do it | right now |  
 | AH-GAH-LOH | AH-OREE-TAH |

(cuando es tiempo para sentarse, acuéstese de lado, doble las rodillas, despacio retire su cuerpo de la cama. hágalo ahorita.)

17. | Sit up | and | rest | fifteen |  
 | SEE-EN-TEH-SEH | EE | DES-KAUN-SEH | KEEN-SEH |
- | or | thirty | minutes || then |  
 | OH | TRAIN-TAH | MEE-NU-TOHS || LU-EH-GOH |
- | lie down | in | the | same | way |  
 | AH-COOES-TEH-SEH | EN | EL | MIS-MOH | MOH-DOH |
- | that you got up | Lie down | right now |  
 | KEH SEH LEH-VAUN-TOH || AH-COOES-TEH-SEH | AH-OREE-TAH |

(siéntese y descanse quince o treinta minutos, luego acuéstese en el mismo modo que se levantó. acuéstese ahorita.)

18. | If | you smoke || try | not to smoke | the |  
 | SEE | FOO-MAH || TRAH-TEH | DEH NO FOO-MAR | LAH |
- | night | before | your | operation |  
 | NOH-CHEH | AUN-TEHS DEH | SUE | OH-PERAH-SEE-ON |

(si fuma, trate de no fumar la noche antes de su operación.)

19. | With | less | smoking | | you have | the |  
 | CON | MEH-NOHS | FOO-MAR | | TEE-EN-EH | LOHS |  
 | lungs | more | clean |  
 | PULL-MON-ES | MAHS | LIM-PEE-OHS |

(con menos fumar, tiene los pulmones más limpios.)

MEDICINE:

20. | After | your | operation | | if |  
 | DES-POO-ES DEH | SUE | OH-PERAH-SEE-ON | | SEE | |
 | you | need | medicine |  
 | OOZE-TED | NEH-SEH-SEE-TAH | MEH-DEH-SEE-NAH |  
 | for | the | pain | | call | the |  
 | PAH-RAH | EL | DOH-LOR | | YAH-MEH | LAH |  
 | nurse | and | tell her | the |  
 | EN-FER-MEH-RAH | EE | DEE-GAH-LEH | LAH |  
 | word | "pain" | | Say | the |  
 | PAH-LAH-BRAH | "PAIN" | | DEE-GAH | LAH |  
 | word | right now |  
 | PAH-LAH-BRAH | AH-OREE-TAH |

(después de su operación, si usted necesita medicina para el dolor, llame la enfermera y dígame la palabra "pain." diga la palabra ahorita.)

21. | If | you feel |  
 | SEE | SEH SEE-EN-TEH | CON EL ES-TOH  
 | sick to your stomach |  
 | CON EL ES-TOH-MAH-GOH REH-VOO-EL-TOH |  
 | after | the | operation | | stay | |
 | DES-POO-ES DEH | LAH | OH-PERAH-SEE-ON | | KEH-DEH-SEH |  
 | to one side | | Ring | the | call bell | and |  
 | DEH LAH-DOH | | TOH-KEH | EL | TIM-BREH | EE |  
 | start | to | breath | slowly |  
 | EM-PEE-EH-SEH | AH | RES-PEE-RAHR | DES-PAH-SEE-OH |  
 | and | deeply |  
 | EE | PRO-FOON-DOH |

(si se siente con el estómago revuelto después de la operación, quédese de lado, toque el timbre, y empiece a respirar despacio y profundo.)

THE NIGHT BEFORE THE OPERATION:

22. | Usually | DEH AH-COS-TOOM-BREH | | the area | EL LU-GAR | operated on | OH-PEH-RAH-DOH |  
 | will be | SEH-RAH | shaved | RAH-SUE-RAH-DOH | | The shaving | LAH RAH-SUE-RAH | |
 | eliminated | EH-LEE-MEE-NAH | microorganisms | MEE-CROW-BEE-OHS | that | KEH | cause | COW-SAUN |  
 | infection | IN-FEK-SEE-ON |

(de acostumbre, el lugar operado será resurado, la resura elimina microbios que causan infección.)

[\*Include #23 only if ordered by the doctor.]

23. | The | EL | doctor | DOK-TOR | has ordered | AH OR-DEN-AH-DOH | an | OONA |  
 | enema | LAH-VAH-TEE-VAH | for | PAH-RAH | you | OOZE-TED |

(el doctor ha ordenado una lavativa para usted.)

24. | Your | SUE | operation | OH-PERAH-SEE-ON | will be | SEH-RAH | tomorrow | MAH-KNEEAH-NAH |

(su operación sera mañana.)

25. | Do not | NO | eat | KOH-MAH | nor | KNEE | drink | TOH-MEH | anything | NAH-DAH |  
 | after | DES-POOES DEH | midnight | MEH-DEE-AH NOH-CHEH |

(no coma ni tome nada después de media noche.)

THE MORNING BEFORE THE SURGERY:

26. | In | the | morning | before |  
 | EN | LAH | MAH-KNEE-AH-NAH | AUN-TEHS DEH |
- | your | operation | take | your |  
 | SUE | OH-PERAH-SEE-ON | TOH-MEH | SUE |
- | bath | early | If | it is |  
 | BAH-KNEE-OH | TEM-PRAH-NOH | SEE | ES |
- | necessary | someone | will help you |  
 | NEH-SEH-SAH-REE-OH | AL-GEHEN | LEH AH-YOU-DAH-RAH |

(en la mañana, antes de su operación, tome su baño temprano. si es necesario, alguien le ayudará.)

27. | Remove | hairpins | jewelry |  
 | KEY-TEH-SEH | IN-KAH-IB-LEHS | HO-YAHS |
- | wig | glasses |  
 | PEH-LU-CAH | AUN-TEH-OH-HOS |
- | false teeth | underwear |  
 | DEE-EN-TES POS-TEE-SOHS | ROH-PAH IN-TEH-REE-OR |
- | and | give them | all | to | your |  
 | EE | EN-TREEH-GEH | TOH-DOH | AH | SUE |
- | family |  
 | FAH-MEE-LEE-AH |

(quítese incaíbles, joyas, peluca, anteojos, dientes postizos, ropa interior, y entregue todo a su familia.)

28. | Urinate | early | in | the | morning |  
 | OH-REE-NEH | TEM-PRAN-OH | EN | LAH | MAH-KNEEAH-NAH |

(orine temprano en la mañana.)

29. | You will receive | an | injection |  
 | REH-SEE-BEH-RAH | OONA | IN-YEK-SEE-ON | |
 | in about | one | hour | before |  
 | KOH-MOH EN | OONA | OH-RAH | AUN-TEHS DEH |  
 | you go | to | the operating room |  
 | EER | AL | COOAR-TOH DEH OH-PERAH-SEE-ON |

(recibirá una inyección como en una hora antes de ir al cuarto de operación.)

30. | The | injection | causes |  
 | LAH | IN-YEK-SEE-ON | COW-SAH | |
 | drowsiness | and | mouth | drying |  
 | DOR-MIN-EN-SEE-AH | EE | BOH-KAH | SEH-KAH |

(la inyección causa dorminencia y boca seca.)

31. | You | will be put to sleep | in | the |  
 | (LOH) (LAH) | DOR-MEH-RAUN | EN | EL |  
 | (male) (female) |  
 | operating room |  
 | COO-AR-TOH DEH OH-PERAH-SEE-ON |

((lo) (la) dormirán en el cuarto de operación.)  
 (hombre) (mujer)

32. | After | your | operation |  
 | DES-POO-ES DEH | SUE | OH-PERAH-SEE-ON ||  
 | you | will be taken | to | another |  
 | (LOH) (LAH) | VEH-VAH-RAUN | AH | OH-TROH |  
 | (male) (female) |  
 | room | until | you wake up |  
 | COO-AR-TOH | AHS-TAH | KEH DES-PEE-ER-TEH |

(después de su operación, (Lo) (La) llevarán a  
 (hombre) (mujer)  
 otro cuarto hasta que despierte.)

33. | When | COO-AUN-DOH | | you wake up | DEES-PEE-ER-TEH | || | you | (LOH) (LAH) | | (male) (female) | |
- | will be returned | REH-GREH-SAH-RAUN | | to | AH | | your | SUE | | room | COO-AR-TOH | |
- (cuando despierte, (Lo) (La) regresarán a su  
(hombre) (mujer)  
cuarto.)

34. | During | DOO-RAUN-TEH | | the | LAH | | operation | OH-PERAH-SEE-ON | || | your | SUE | |
- | family | FAH-MEE-LEE-AH | | may | POO-ED-DEH | | wait | ES-PEH-RAHR | |
- | in | EN | | the | LAH | | waiting room | SAH-LAH DEH ES-PERA | | on | EN | | this | ES-TEH | |
- | floor | PEE-SOH | |

(durante la operación, su familia puede esperar en la sala de espera de este piso.)

35. | When | COO-AUN-DOH | | the | LAH | | operation | OH-PERAH-SEE-ON | | has been | AH SEE-DOH | |
- | finished | TER-MIN-AH-DAH | || | your | SUE | | family | FAH-MEE-LEE-AH | | will be | SEH-RAH | |
- | notified | AH-VEE-SAH-DAH | | by | POR | | the | EL | | doctor | DOK-TOR | | or | OH | | the | LAH | |
- | nurse | EN-FER-MEH-RAH | |

(cuando la operación ha sido terminada, su familia será avisada por el doctor o la enfermera.)

DISMISSAL AND EXIT:

Thank you	for	you	cooperation
<u>GRAH-SEE-AHS</u>	POR	SUE	COH-OH-PERAH-SEE- <u>ON</u>

(gracias por su cooperación.)

May you have	a	good	day	tomorrow
KEH <u>PAH-SEH</u>	OON	BOO- <u>EN</u>	DEE-AH	MAH- <u>KNEEAH-NAH</u>

(que pase un buen día mañana.)



## APPENDIX G

## QUESTIONNAIRE

Please use an   X   or answer the following:

Age \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Educational Level: Junior \_\_\_\_\_ Senior \_\_\_\_\_

Nursing School \_\_\_\_\_

Previous experience with/or exposure to the Spanish language:

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, briefly explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The following questions are related to:

- (1) The bilingual English-Spanish phonetic preoperative instruction guide.
- (2) The instructions that you gave to the monolingual Spanish-speaking person.

The purpose of this group of questions will be to evaluate the usefulness of the technique you need to give preoperative instructions. Please place an   X   mark under the answer. Thank you for your assistance and cooperation.

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Agree
1. The guide helped in actively involving the "patient" with the preoperative exercises.					
2. The language barrier between the nurse and the "patient" was narrowed through the use of the guide.					
3. The Spanish phonetic words were simple to pronounce to the "presurgical patient."					
4. The "patient" responded appropriately to specific instructions.					
5. Instructing the "presurgical patient" with the guide was a comfortable experience.					
6. The guide was useful in giving preoperative instructions for postoperative care.					
7. The manner in which the instructions were presented in the Instruction Guide was simple to use.					

Please state briefly what aspect of the guide was most helpful to you.

Please state briefly what aspect of the guide was least helpful to you.

## APPENDIX H

## RECORDING FORM

For the purpose of this study, the healthy Spanish-speaking person will assume the role of a presurgical patient. The following questions will focus on:

- (1) Behavioral responses as noted by nonparticipating observer.
- (2) Verbal responses as answered by the Spanish-speaking person.
- (3) The Spanish-speaking person's view of the method used to give him the preoperative instructions.

BEHAVIORAL (an X marks the observation response from the "patient's" behavior.)

Instruction	Patient performed demonstration				Comments
	The 1st Time	The 2nd Time	The 3rd Time	Not at All	
1. Breath deeply					
2. Cough					
3. Lie on one side					
4. Bend knees					
5. Straighten legs					
6. Sit up in bed					
7. Lie down in bed					
8. Say "pain" when in need of medication					

VERBAL (an X is placed under the response given by the "patient.")

Question	Answer	1st Time	2nd Time	3rd Time	Not at all	Comments
1. When are you to do your exercises?	Following the operation					
2. If you smoke, why should you try not to smoke before an operation?	The lungs would be cleaner.					
3. What should you do if you become nauseated?	Stay on side, call nurse, breathe slow and deep.					
4. Why is the area to be operated on shaved?	It eliminates bacteria.					
5. Before an operation, what time of the night are you not to eat or drink anything?	Midnight.					
6. Before an operation, you remove hairpins, jewelry, wig, glasses, false-teeth, underwear, and give them to who?	Family.					
7. You will receive an injection about one hour before the operation. What will the injection do to you?	Drowsiness and dry mouth					

Question	Answer	1st Time	2nd Time	3rd Time	Not at all	Comments
8. In the morning, you are to urinate before going to the operating room and before receiving what type of medication?	Injection.					
9. After an operation, when will you be returned to your room?	When awake.					
10. During an operation, your family waits in the waiting room on this floor. Who notifies your family when the operation is over?	Doctor or nurse					

11. Were you able to understand the information the nurse read to you with the guide?

YES \_\_\_\_\_ NO \_\_\_\_\_

12. Did the information tell you what you need to know before an operation?

YES \_\_\_\_\_ NO \_\_\_\_\_

13. Did you like the way the nurse, who speaks no Spanish, gave the information concerning an operation?

YES \_\_\_\_\_ NO \_\_\_\_\_

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AN EVALUATION OF A BILINGUAL PREOPERATIVE  
INSTRUCTION GUIDE FOR THE MONOLINGUAL  
SPANISH-SPEAKING PERSON

ABSTRACT

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May, 1976

The problem of this study was to determine the effectiveness of a phonetic bilingual preoperative instruction guide for the monolingual Spanish-speaking person utilized by the monolingual English-speaking nurse.

The purposes were to develop a tool to set up basic communication between the monolingual Spanish-speaking person and the monolingual English-speaking nurse, and to determine if the phonetic preoperative instruction guide provided effective communication.

Two types of populations participated in the study. There were thirty student nurses selected from baccalaureate nursing programs who did not speak fluent Spanish. Also, thirty non-English-speaking healthy persons participated in the study.

The major study was conducted in the Spanish-speaking communities of Dallas, Texas, in their homes. The student nurse read the phonetic preoperative instructions to the Spanish-speaking person, then, when finished, exited

from the testing room to answer a questionnaire. Meantime, the Spanish-speaking person was asked short, leading questions to elicit reactions to the verbal instructions given by the student nurse.

The bilingual phonetic preoperative instruction guide, the student-nurse questionnaire, and the recording form were the principal tools for the collection of data. Frequency distributions were utilized to determine various aspects of the collected data.

Analysis of the Spanish-speaking participants indicated: (1) their average level of education was grade school and (2) the country where the majority were educated was Mexico. A total of 90.5 percent of the Spanish-speaking participants understood and correctly responded to the phonetic instructions as given by the students. The majority of the students, 88.1 percent, agreed the guide was useful in providing effective communication.

Based on the findings of the data collected, the following conclusions are offered: (1) the guide was understood by Spanish-speaking participants of grade-school level education, (2) the Bilingual Phonetic Preoperative Instruction Guide was useful in providing an effective method of communication, and (3) the following alteration in the format of the guide would be helpful to those who administer the guide: the addition of a question requiring an indication of understanding by the patient of each instruction given.