AMA Journal of Ethics®
April 2022, Volume 24, Number 4: E313-318

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Language and Health (In)Equity in US Latinx Communities

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Abstract

Language is a social determinant of health, no less so in the case of Latinx persons, who make up the second largest ethnic group in the United States. In US health care, language and linguistic difference are often conceived in discrete, instrumental, and monolithic terms. This article characterizes this conception of language as administrative logic, which is in sharp contrast to language conceived as a richly complex, heterogeneous, communally lived human experience. This article emphasizes the importance of system-level language awareness and epistemic humility for promoting equity, as well as the need to avoid too-narrow focus on linguistic assessment.

Administrative Logic

Many residents of the United States, including health care workers, are aware that Latinx make up the second largest ethnic/racial minority group in the United States. Less often realized is the heterogeneity that underlies this classification.[1] (We use the label *Latinx* throughout primarily for reasons of thematic and conceptual coherence with the rest of the contributions in the thematic issue, while recognizing the social significance and political salience of relevant competing or interrelated notions, such as *Latinidad* and *Indigenidad*.) In what follows, we outline the implications of the sociolinguistic context of US Latinx for their clinical care. More specifically, we consider the ways in which the quality and equity of care provided to US Latinx are affected by a profound tension between the Anglo-centric and often monolingual administrative logic of health care institutions, on the one hand, and the complexities of Latinx' linguistic lived experience of health and illness, on the other. More specifically, we offer a critique of this administrative logic in the context of health care, and we examine how a less regulative-centered conception of language and linguistic agency can better serve health care policies and practices committed to equality, diversity, and inclusion and likewise guide their development, implementation, and assessment.

Heterogeneity in Latinx Linguistic Identities

The goal of equitable health care delivery to US Latinx—and to other US demographic groups—has a critical linguistic dimension. Most studies show that linguistically concordant care improves health outcomes.[2,3] Linguistically discordant care often leads to patient dissatisfaction, lower quality of care, inappropriate follow-up, and worse health outcomes.[4,5] That is, care in a language other than that preferred by the patient

can "expose" poorer quality care and lead to deleterious or disparate outcomes. These findings, however, do not imply that addressing this discordance necessarily entails slotting any and all Latinx patients into the Spanish language administrative rubric. Not all Latinx speak Spanish as their first or primary language or even speak it at all (eg, Indigenous migrants, whose experience of the immigration system involves similar discordance).[6] Even those who do speak Spanish may not speak the specific variety of the language assumed by the institution. This state of affairs further compounds the extent of linguistic disadvantage experienced by Latinx individuals seeking care.

To take another example, the perceived ubiquity of Spanish—a spoken language—can also marginalize Deaf and hard-of-hearing Latinx, who face, alongside the numerous socioeconomic and psychosocial factors involved in acculturation, "additional factors unique to their situation, such as community attitudes about disability, multilingualism (some people have to navigate up to four languages), multicultural values, exposure to multiracial communities, limited availability of mediators (Deaf individuals of their own country), and family issues."[7] Their linguistic repertoires will necessarily be reflective of their individual linguistic histories and experiences with regard to, for example, access to sign language in country of origin, the specific sign language(s) of that country, opportunities to acquire multimodality and multilingualism in signed and spoken languages, and so on.[7] These complex linguistic identities—and the divergent communicative preferences and needs that arise from them—highlight the factual error (and practical inadequacy) of equating Latinx with Spanish speaking.

Monolingual Ideology as a Source of Harm

The underlying multidimensional sociolinguistic diversity of US Latinx can serve as entrée to a linguistic state of affairs often overlooked by busy clinicians, overwhelmed patients, and harried administrators, many of whom are rarely trained specifically in navigating multilingual and multimodal realities arising from linguistic difference. US hospitals and health care systems are commonly constructed on a presupposition of a monolingual linguistic culture, dominated by the unrivaled power of English. Such administrative logic, particularly when coupled with monetary incentives geared towards serving well-off patients, means that the complex linguistic heterogeneity of US Latinx is very rarely recognized in the clinical setting.

Such administrative logic cannot be understood as purely instrumental and value neutral, however. Rather, it is rooted in a distinct ideology in which language is viewed as an autonomous entity used for conveying information.[8] Linguistic difference is thus conceived as a problem, reflected in its being labeled as a barrier, because such difference introduces potential errors in information transmission and resulting inefficiencies.[8] These beliefs constitute a type of linguistic ideology according to which the perceived problem of language needs to be solved through intervention, a view that is often linked to the social and cultural subordination of the less linguistically powerful.[8] This orientation affects the care of linguistically heterogeneous Latinx in the United States in envisaging language difference primarily as a problem that requires a solution, but it is far less concerned with the power relations that define the parameters of the problem or the terms of its proposed solutions.

Linguistic Difference in Health Communications

Linguistic discordance is not merely affected by linguistic difference in the narrow sense of the difference between language A and language B. Even when both languages are understood in more inclusive terms (eg, not restricted to standardized, high-resource

spoken varieties), the existence of a language barrier is further compounded by additional layers of critical difference. For example, there is a (perceived) gap in epistemic authority and credibility between the globally powerful languages of science and technology that dominate contemporary transnational knowledge development and production and less powerful languages in which conceptions of health, illness, and well-being are grounded in local and traditional knowledge systems.

There are also other layers of linguistic difference. Linguistic differences might arise in the care of individuals with complex communication needs (eg, various communication disorders). Still another vitally important layer pertains to the difference between habitual language and disrupted linguistic agency (eg, the profound experience of "indescribability" in depression[9]). In another example, the complex linguistic response to trauma, in terms of both experience and narration, may drastically affect a person's habitual interaction with linguistic interlocutors, as manifested in "his or her inclination to learn languages, to use, retain, or abandon a particular language, or to take refuge in silence."[10] Health care practitioners—and institutions more broadly—should not lose sight of these additional layers in planning and evaluating the care they provide to linguistic minorities.

The inadequacy of slotting Latinx patients into neat language boxes, or the tendency to see language only as a barrier rather than as intrinsically linked to individual and societal complexity, is even more relevant in the current Covid-associated syndemic.[11] In the context of the clinical experience of the first author (Z.B.), a common assumption of administrative logic is that merely replacing English with Spanish is enough to fully meet the communicative needs of Latinx during the Covid-19 pandemic, an assumption that, in addition to overlooking Latinx' linguistic heterogeneity, fails to acknowledge the intersection of economic, social, political, and juridical constraints on this community.

Cultivating Linguistic Humility

These considerations illustrate just how complex and multifaceted health communication is even in supposedly linguistically concordant settings, let alone in their discordant counterparts. They also emphasize the need to keep in mind that interpretation—even in best-case scenarios when it is available, funded, and certified—is better envisaged not as a fix to communicative barriers but rather as a tool that needs to be properly utilized and whose benefits as well limitations need to be understood.[12] The awareness that interpreters are not merely language conduits between language A and language B and the need to reconcile and calibrate the different perceptions of all parties involved in interpreted health communication[13] constitutes another important insight into the crucial shortcoming of an uncritical conception of language (eg, discrete, instrumental, disembodied) that often underlies the administrative logic of health care institutions.

It is pivotal to highlight that an uncritical conception of language is not merely a theoretical or intellectual preoccupation. Rather, it has a clear and immediate effect on the efficient utilization of various resources and services provided with the aim of delivering equal care to patients of all linguistic profiles and identities. Concerns about the cost of such services (eg, translation and interpretation, cultural liaison, and patient navigator capacities), given real-world resource limitations, rarely address the problem of their inefficient utilization by clinicians and administrators due to lack of sufficient language awareness. For example, an administrator might incorrectly infer on the basis of minimal input (eg, a greeting, asking directions) that a patient in fact speaks English

and therefore dismisses the interpreter. Or a clinician might request sign language interpretation to communicate with a Deaf patient without being aware that there exists more than a single sign language and that different sign languages are not necessarily any more mutually intelligible than different spoken languages are. We thus suggest that cost-related concerns over linguistic accessibility in health care ought to be considered—and perhaps also reevaluated—in relation to the question of whether or not health care institutions are in fact sufficiently language aware to adequately utilize the existing range of resources[14] and how to assess ongoing and future needs.

Relatedly, we also wish to emphasize that attempts to "fix the (interpretation) fix" on the part of practitioners with some competency in the patient's language, by cutting out the (communicative) middleman altogether, should be regarded with caution. Such shortcuts incur the risk of false fluency and the encouragement of an institutional linguistic culture of "getting by" at the expense of certified interpretation.[15] This tendency is reinforced by the expectation on the part of some academic medical centers that in-person interpretation is a dispensable luxury, completely replaceable by video or audio equivalents.

Our point is not to completely discourage practitioners from using their linguistic competency in such encounters. Indeed, we are mindful of the risk that an institutional linguistic culture centered on formal assessment and credentials might result in appropriating language from noncertified bilingual practitioners and minimizing the contribution of domestic speakers of the language.[8] Rather, we seek to highlight the importance of clinicians developing a sense of linguistic epistemic humility based on "an attitude of awareness … of their own linguistic epistemic capacities … the recognition of their limitations, and the active search for sources outside one's own linguistic epistemic capacities to help overcome them."[16] In the context of health care provision for US Latinx, linguistic epistemic humility entails not simply an honest self-assessment of one's Spanish competency, but also the capacity to assess the degree of relevance of Spanish to begin with, given the linguistic heterogeneity among Latinx patients, as described above.

Conclusion

Making health care institutions more linguistically inclusive for Latinx patients entails challenging a monolingual and Anglo-centric administrative logic. However, doing so requires more than simply equating Latinx with Spanish speaking. A better-informed understanding of the spoken and signed linguistic heterogeneity of US Latinx is fundamental for a more equitable health care delivery committed to patients' equal linguistic dignity. Power often gives rise to an unexamined assumption of sufficient knowledge,[17] whose presence can be detected in the linguistic ideologies that underlie the administrative logic of present-day health care systems and institutions. Challenging the assumption of sufficient knowledge by pursuing enhanced linguistic understanding can therefore contribute significantly to addressing present-day US Latinx health inequities.

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Citation
AMA J Ethics. 2022;24(4):E313-318.

DOI
10.1001/amajethics.2022.313.

Conflict of Interest Disclosure
The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

ISSN 2376-6980