Spanish in Health Care

*Spanish in Health Care* fills an important gap by offering a panoramic overview of the research on Spanish in health settings that is emerging from a variety of disciplines.

Synthesizing research from diverse disciplines such as sociolinguistics, discourse analysis, health services research, behavioral health research, health policy and administration, and social epidemiology, the volume offers a uniquely unified approach to the subject of Spanish in healthcare.

This volume will be of interest to researchers in Spanish linguistics, sociolinguistics, health communication, and languages for specific purposes.

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**Spanish in Health Care**  
Policy, Practice and Pedagogy in Latino Health  
*Glenn A. Martínez*  

To the memory of Agustín R. and Ofelia Martínez and to my students, past and present, who continue to teach me about the power in language to improve health.
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My name is Maribel Garza. I have three children: one boy and two girls. My
youngest daughter is Malena. She is twelve years old, and this is our story.
Malena has always been a darling young person. As a baby, her beaming
brown eyes and her crooked smile could light up any room. I would dress
her up in cute dresses and put matching bows in her hair to complement
her natural disposition. Every time I walked down the street or entered a
store, people would stop me and ask to give the child “un cariño.” While
Malena was always outwardly pleasant, she was a bit introverted, I admit.
I will never forget Malena’s seventh birthday. It was that day that my life
changed forever. It was around 2 a.m. when I heard a howling screech com-
ing from the girls’ room. I jumped out of bed petrified and ran as fast as
I could to their room. Malena was standing on her bed, crying hysterically –
¡quítamelos, quítamelos! Malena’s sister and I ran up to her and grabbed
hold of her stiff arms – ¡quítamelos, quítamelos! ¡Los bichos – quítamelos!
Seeing nothing on her arms, I immediately ripped the sheets off the bed
and found nothing. ¡Quítamelos, quítamelos! Malena continued to cry.
I remember picking her up and bringing her with me to my room. Sitting in
bed, I rocked her, sung her a lullaby, and prayed that God would give her
peace. I was terrified.

The next day I took Malena to the doctor. After a battery of tests and
three appointments later, I was told that Malena had schizophrenia, severe
autism, epilepsy and developmental delay. It was a life shattering experi-
ence. I never imagined myself on such a steep uphill climb. I’m a single
mom and it’s so hard for me to keep a job and provide for all of the medical
needs of my daughter. I enrolled in night classes at cosmetology school and
put a small beauty salon in my house. I don’t make a lot of money, but at
least I can be home with Malena. Malena is on medication for the halluci-
nations and spends most of her time at home – in her room, wandering the
halls, and talking to herself. It’s just hard – it’s hard to talk to her. I wish
I could do more for her. It’s just hard – it’s hard to deal with this system in
the U.S. I don’t speak English very well.
I have trouble talking to my daughter’s teachers. We have meetings to
discuss Malena’s academic needs. They tell me they are going to do every-
thing in their power to help her, but they never keep their promises. I feel
ignored most of the time. School is really just day care. My daughter is
twelve years old and can’t read; she doesn’t know how to add or subtract;
she rarely speaks in complete sentences. It’s frustrating. I feel like I don’t
have a voice – like I’m almost invisible. And school is just the beginning.
I feel just as helpless with the doctors. The nurses and receptionists are just
plain rude. I feel as if they are mad at me because I don’t speak English,
and they scold me for arriving late to my appointments. Oftentimes, I have
appointments with several doctors on the same day. If one doctor is late,
I will be late to all my other appointments. It’s also hard for me to follow all
the doctors’ instructions. My daughter’s neurologist, for example, ordered
one-on-one help for Malena at school. I had to fight with the school to get
it, and to this day it hasn’t happened. The people at the pharmacy are very
helpful. Malena takes six different medications every day. The pharmacists
give me medicine bottles with different colored lids to help me keep every-
thing straight.

Every day is a battle – a struggle to help my child. I think if I spoke
English, the doctors, nurses, receptionists and teachers would take me more
seriously. I’m taking English classes to learn English – one day I will be
able to help my child more, one day when I know English.

Story by Cynthia M. Gonzalez (Used with permission)

I begin with this story because it is illustrative of the multiple and intersectional
impacts of language on the health and well-being of Latino populations in the
United States. While this story presents only one perspective of a larger narrative –
that of a struggling caregiver – it sheds light on the entanglements of language,
health care and health that are the focus of this book. Maribel’s struggles with
language are far-reaching and diverse. They affect her ability to negotiate opti-
mal outcomes with her child’s teachers and they impact her interactions in health
care settings. When looking at Maribel’s struggles, we might be tempted to focus
on the adverse outcomes that the language barrier is producing in her child.
Malena cannot read; she cannot add and subtract. Malena’s medical condition is
not improving – instead it’s deteriorating. Following doctors’ recommendations
is a challenge and keeping up with the hectic pace of multiple treatments is dif-
ficult. Yet, the impact of Maribel’s struggles far surpass the poor outcomes of
her child’s care and takes a toll on Maribel herself. She feels invisible, unheard.
She is frustrated by the neglect of officials entrusted as partners in her child’s
welfare – teachers, school administrators, doctors, and nurses. She is caught in
the crosscurrents of multi-morbid chronic care treatment and the wider economic
demands and social expectations imposed upon her. She feels guilty because her
ability to arrive at appointments on time and to follow doctor’s orders are often-
times beyond her reach. Added to the poor outcomes of her child’s care are these
more self-debilitating outcomes in Maribel herself. Maribel’s feelings of guilt and
impotence, moreover, cannot be bracketed off from the overarching experience
and burden of illness. Each instance of micro-aggression experienced in the doc-
tor’s office, each promise made and not kept by school officials feeds right back
into the overwhelming burden she deals with day in and day out and adds to
the frustration of seeing little progress in her daughter’s treatment. In spite of it
all, however, Maribel is resilient. Maribel looks out on the horizon and sees just
beyond it to that “one day” – that one day when she will be able to help her child
more, that one day when she knows English.

Overview of the book

Maribel’s resilience, her faith in that “one day,” is the impetus of this book. Per-
haps she is overly optimistic about the influence of knowing English. Perhaps
simply knowing English would not fundamentally change her plight. But this
book looks beyond her faith in English to her deep-seated desire to improve the
health outcomes and the well-being of her child. The foundation of Maribel’s
resilience is found at its core in this overriding desire – in her desire that “one day”
she will be able to help her child more. It is this desire that leads me to ask: What
role do language professionals – Spanish teachers, English teachers, interpreter
trainers, and language researchers – play in getting to that “one day” that drives
Maribel’s resilience? What perspectives do language professionals bring to the
broader discussions about Latino health and well-being and the elimination of
health disparities in Latino populations?

Language, and the literacies that it generates and sustains, have long been rec-
ognized as critical factors in addressing health disparities in Latino populations
in the United States. Language educators, sociolinguists, and literacy researchers,
have not played a central role in assessing the causes of and developing
interventions to address these disparities. The missing voices of language spe-
cialists in research on language access in health care have led to an undertheo-
rized approach to the numerous linguistic and sociocultural challenges that affect
Spanish speakers in the U.S. health delivery system. Spanish in Health Care:
Policy, Practice and Pedagogy in Latino Health is written to provide scholars and
students in Spanish linguistics, sociolinguistics, and applied linguistics a broad
perspective of the linguistic challenges faced by Spanish speakers in the health
delivery system, to familiarize them with the established and emerging literature
in the field, and to point them to particularly pressing areas of future sociolinguis-
tic and applied linguistic research.

In this chapter, I will consider the role of language in Latino health. I will first
consider the relationship between language and health. As sociocultural per-
spectives have been introduced both in the study of health care and the study of
language, the two areas have converged in ways that reveal previously unseen
spaces of overlap, synergy, and reciprocity. I will explore these spaces in depth
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offering a model for the analysis of language and health on two separate planes: the communicative plane and the ideological plane. With this model in mind, I will then explore the emergence of latinidad and describe its role in current formulations of Latino health. I will review various epidemiological studies that explore the relationship between language and health in Latino populations. Finally, I will show how the findings of these studies have been assessed under two distinct interpretive frameworks: the social determinant perspective and the syndemic perspective. The social determinant perspective considers language and language-related phenomena to be causal factors in health disparities. Language is viewed as a distal factor in the chain of causality that leads to poor health outcomes. The syndemic perspective, on the other hand, does not discount the role of language as a causal factor but rather emphasizes the ways in which language both generates poor health outcomes and fundamentally shapes the experience of those outcomes.

Chapter 2 draws on the theoretical framework of syndemics to describe language policies in health care that affect Spanish speakers in the U.S. After a brief consideration of the major questions that have emerged in health policy, I will discuss the historical background of U.S. language policy and how this background has shaped language policy in health care at the national and state levels over the past two decades. I assess these policy interventions on ideological grounds in order to demonstrate the intimate relationship between language policy and health policy. I wrap up the discussion by underscoring the multiple ways in which language in health care policy affects the lives of Spanish speakers.

In Chapter 3, I begin an extended discussion of the language and cultural practices in health care that interact with the policy environment discussed in Chapter 2. In this chapter, I argue for the need for a practice perspective in the study of communication in Spanish in health care contexts. A focus on language and cultural practice, as opposed to a focus on language and culture, helps us move away from the notion that language and culture are preexisting bodies of knowledge and skills that are brought to the health care encounter and to move towards a notion of language and culture as co-constructed in health care encounters themselves. In applying this notion to health communication, I review various theoretical frameworks including health behavior theory, provider-patient communication, interpreter-mediated communication, and cultural values and beliefs. I further explore the limitations of these theories in accounting for a practice perspective on language and culture.

Chapter 4 takes up the practice perspective described in the previous chapter and reviews studies of provider-patient communication, interpreter-mediated communication, and health literacy and health information seeking in Spanish-speaking communities. In synthesizing the research, I explore the multiple tensions that have arisen in the literature and their relationship to existing policy. I conclude the chapter by arguing for a communication ecology approach to Spanish in health care that can inform policy and account for the multiple language and cultural practices enacted by Spanish speakers in health care settings.
In Chapter 5, I move away from a focus on practice to consider the pedagogical implications of communication research with Spanish speakers to the teaching and learning of Medical Spanish. I review the development of Medical Spanish beginning as early as the 1930s. I describe the role of Languages for Specific Purposes in shaping Medical Spanish in the present, and I argue for a more nuanced approach to the teaching of Medical Spanish that I call Spanish for Latino Health. Spanish for Latino Health is conceived of as an expansive agenda for Medical Spanish that broadens the focus of instruction to include engagement with health/communicative inequities, ethical listening, and translanguaging.

The three strands of Spanish in health care described in this book – policy, practice, and pedagogy – are meant to contribute to a more complete understanding of communication in Latino health and to provide substantive information for researchers and teachers who are just entering the field of Spanish for health care. At the beginning of each chapter, I include vignettes that bring out issues of culture, identity, and language in health care contexts in order to engage the reader with the real-world issues that undergird the theoretical perspectives outlined in the book. These stories are culled from years of teaching Spanish to students – both heritage and second language learners – aspiring to enter the health professions. I am grateful to Cynthia Gonzalez, Aaron Salinas, Karmín San Martín, Alex Rodriguez, and Palmira Cepeda for granting me permission to use their powerful stories. I hope it will be evident to the reader how much I have learned from these stories and that they will serve not only as a solid basis for the discussions pursued in each chapter but also as a pattern of learning through teaching that must remain the cornerstone of language teaching for social justice.

### How language affects health

To speak of the relationship between language and health is to cover an enormous conceptual stretch. A novice might approach the topic wondering how the specific set of lexical items and grammatical rules a person uses to communicate impinges on the presence of diseased states in that individual. However, such an approach would miss much of the larger conceptualization of both language and health. The World Health Organization (WHO), as early as 1946, adopted a view of health that eschewed the notion that health is simply the absence of disease. According to the WHO, “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946). By this definition, the question of the relationship between language and health requires attention not only to disease states but also to the myriad factors affecting complete physical, mental, and social well-being. In the same vein, a view of language as a specific set of lexical items and grammatical rules used to communicate misses the mark of our current conceptualization of language. While Ferdinand de Saussure defined language as “a social property of the faculty of speech and a collection of necessary conventions that have been adopted by a social body to permit individuals to exercise that faculty” (de Saussure, 1987, p. 9), he was quick to distinguish this abstracted notion of “language” from “speech” which he characterized
as “many-sided and heterogenous” and as belonging both to the individual and society. Sausure bracketed off speech from his consideration because he found that in speech there was no unity to be discovered. This same division was held well into the twentieth century and became a foundational tenet of at least one variety of linguistic science. Under this conceptualization, it might be plausible to understand the relationship between language and health as something entirely different from the relationship between health and speech effectively extirpating from the purview of linguistics the whole question of language use or speech in healthcare contexts. Yet, linguistics has not shied away from the consideration of language in use. In fact, a whole field of linguistics, namely sociolinguistics, has emerged that is dedicated principally to understanding how language is used in social contexts for social purposes. Dell Hymes referred to this approach as a “socially constituted linguistics” in which all questions about language are to some extent embedded in social analysis (Hymes, 1997). These pioneering ideas, in conjunction with those proposed by a long line of other scholars, have considerably expanded our notion of what language is and what it means to study it. From the tradition of sociolinguistic scholarship, myriad perspectives on language have emerged including the study of language variation, language stylization, language attitudes and ideologies, language maintenance and shift, and the list goes on and on. What is clear from the legacy of sociolinguistics is that the relationship between language and health – both broadly conceived – is a rich, complex, and multifaceted area of linguistic inquiry.

The relationship between language and health can be viewed from at least two distinct standpoints. First, we can think of language as a determinant of access to care. Language is the vehicle through which patients and providers give and receive information. In the absence of a shared communicative system, access to care will be limited. Limited access prevents patients from expressing symptoms, side effects and other essential information for providers to deliver treatment. At the same time, limited access curtails the patient’s ability to obtain information that is critical for understanding their condition, its symptoms, its treatment, and risk factors that can aggravate it. Limited access to information is perhaps the most obvious adverse effect of language barriers, and it is a significant factor in the relationship between language and health. In Latino populations, the negative impacts of limited access to information have led to tragic consequences.

The story of Gricelda Zamora is one such tragedy. Gricelda was a 13-year old from Yuma, Arizona who, like many children whose parents speak limited English, served as her family’s interpreter. When Gricelda developed severe abdominal pain, her parents rushed her to the hospital. Unfortunately, Gricelda was too sick to interpret for herself, and the hospital did not provide an interpreter. A night of observation passed. Without the aid of an interpreter, her Spanish-speaking parents were told to bring her back immediately if her symptoms worsened or otherwise to follow up with her doctor in three days. The parents, however, understood from the conversation that they should wait three days to see the doctor. After two days, with Gricelda’s condition deteriorating, they felt they could no
longer wait and rushed her back to the emergency room. Doctors there discovered that she had a ruptured appendix. She was airlifted to a nearby medical center in Phoenix. She died a few hours later (Chen, Youdelman & Brooks, 2007, p. 362).

Flores (2006) pointed out another tragic case in which information barriers led to deleterious and avoidable effects. A Spanish-speaking woman brought her two-year old daughter to the emergency room after the child fell off her tricycle. The woman confidently informed the resident that the child had “hit herself.” The resident on call listened to the woman’s explanation and understood that she had hit the child. He proceeded to notify the Department of Social Services, and they immediately sent a case worker to investigate the case. Without an interpreter present, the case worker had the mother sign over custody of her two children (p. 229).

Stories such as these have led policy makers to understand the need to eliminate language barriers in health care. The obvious solution in cases such as these is the use of trained, professional interpreter staff members to bridge the information gap between patients and providers. The field of medical interpreting has grown substantially since the 1990s and today constitutes a vital service for Spanish-speaking patients in the U.S. health delivery system. The medical interpreting profession has developed standards of practice and ethical guidelines to ensure the quality of interpreted medical encounters (Bancroft et al., 2016). The provision of professional interpretation services in the care of non-English speaking patients has rapidly become the standard of care (OMH, 2001; Joint Commission, 2010; OMH, 2013). The use of bilingual health personnel, on the other hand, offers an additional solution. The research on the health benefits of language concordant care have been significant drivers on this front. Recent efforts are moving towards a standardized process of training, validating, and using bilingual health professionals (Tang et al., 2011; Ortega, 2018). We will discuss the pedagogical dimensions of Spanish in health care in greater depth in Chapter 5.

Notwithstanding the advances realized in closing the information gap between English-speaking providers and their Spanish-speaking patients, there are other ways in which language intervenes in health and health care. While language obviously serves a communicative function that is essential in health care encounters, it also serves other functions that sociolinguists have strived to enumerate. Language serves as a bond between its speakers, endearing them to each other (Heath, 1983), and it also serves as a form of symbolic capital establishing and perpetuating social hierarchies (Bourdieu, 1991). Similarly, people fashion their identities through language – stylizing themselves and sometimes crossing, i.e., using the language variety that belongs to another group (Rampton, 2018). These insights into the identity function of language suggest that language differences are never neutral but rather always charged with deep-seated, heartfelt meaning. In her classic work Borderlands/La Frontera, feminist scholar-activist Gloria Anzaldúa underscores this point. “So, if you really want to hurt me,” she writes, “talk badly about my language. Ethnic identity is twin skin to linguistic identity – I am my language. Until I can take pride in my language, I cannot take pride in myself” (Anzaldúa, 1999, p. 81). Language is deeply personal. In her poem “You
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know how to say arroz con pollo but not what you are,” poet Melissa Lozada-Oliva explores what it means to claim Spanish as her own. She writes:

If you ask if I am fluent in Spanish I will tell you. . . . My Spanish is understanding that there are stories that will always be out my reach, there are people who will never fit together the way that I want them to, there are some letters that will always stay silent, there are some words that will always escape me.

(Lozada-Oliva, 2017)

For Lozada-Oliva, language is fundamental not only to her identity but also to her personhood. Her Spanish is who she is.

This identity function of language, embedded as it is in a whole array of social hierarchies, racial and ethnic prejudices, and sociocultural expectations, also impinges on the relationship of language and health. If the communicative function of language limits access to health care, the identity function of language limits and strains acceptance in health care. It is not enough to just have access to information. There is also a need to feel accepted and welcomed in the health care encounter. Lack of acceptance leads to mistrust between patients and providers and has the potential to override any gains realized through access. Lack of acceptance, moreover, shapes dispositions both on the provider and the patient side. Perhaps a patient’s lack of compliance or leaving the hospital against medical advice (Desai, Torres-Rivera & Backes, 2016) is nothing more than a symptom of a lack of trust. Perhaps a doctor’s overutilization of costly tests and increased worries about medical malpractice lawsuits in treating limited English proficient patients stems from a lack of acceptance (Chen, Fang & Rizzo, 2011).

The use of interpreters, however, does little to mitigate the barriers of acceptance occasioned by language barriers. Telephonic interpreter Nataly Kelly, for example, describes how her mediation skills, even while effective in closing the access gap, were useless in bridging the gap of acceptance. She writes:

On the flip side, I’ve witnessed – by phone – some behavior by providers that is offensive or rude. I’ve interpreted for patients who ask, “Why is the doctor speaking so slowly to me? Does he think I’m stupid?” I’ve also interpreted the words, “Please tell the nurse not to yell at me. I don’t have a hearing problem – I just don’t speak English.” Recently I heard a physician say, in all seriousness, “Next time you come, you speak inglés, understand?” as if mastery of a new language would magically occur by the follow-up appointment.

(Kelly, 2008, p. 1704)

Kelly’s observations suggest that something more than interpreters is needed to address this dimension of the language barrier. Some have argued that training health care providers on how to work with an interpreter is needed (Diamond & Jacobs, 2010). Others have contended that successfully confronting these issues requires training in cultural competence (Watt, Abbott & Reath, 2016). While
both may be partially on point, it is important to realize that language acceptance is part of a much larger habitus in which health care is couched. Habitus is a concept developed by Pierre Bourdieu as part of a much more complex theory of practice (Bourdieu, 2002). He speaks of the habitus as “systems of durable, transposable dispositions” that are deployed in “regulated and regular” form without being “the product of the orchestrating action of a conductor” (Bourdieu, 1990, p. 53). Habitus thus refers to values, attitudes, ideologies, and actions that are adopted unconsciously as part of membership in a particular field. With respect to language, we might conceive of a series of dispositions about the normal, normative language to be spoken in public space. Those dispositions are challenged when a doctor must dial a phone and connect to an interpreter in order to converse with a patient. The dissonance caused by the challenging of these dispositions then results in the type of encounter chronicled by Kelly.

Seth Holmes (2013), in his ethnography of Oaxacan migrant farmworkers, argues that cultural competency training models often fail to adequately frame the problem of the larger habitus. He contends that most cultural competency training programs focus on lists of stereotypical cultural traits and thus implicitly present culture as the problem. Instead, he argues, following Jonathan Metzl, that medical educators should focus on social analysis and structural competency rather than on cultural competency (p. 153). Tervalon and Murray-García (1998), on the other hand, proposed the notion of cultural humility as an alternative to cultural competency that would address the larger habitus of health care. Cultural humility proves to be a more powerful concept than cultural competence inasmuch as it attempts to reframe competence in terms of dispositions rather than in terms of knowledge or skills. Cultural humility is approaching other cultures with a pervasive desire to learn; it is listening attentively; it is not assuming a shared perspective. Cultural competence is something you achieve once and for all, but cultural humility is something you do over and over again. Cultural humility is founded on three principles: lifelong learning, power imbalances, and institutional accountability. The practice of cultural humility is characterized by a persistent disposition to learn. It is characterized by a recognition of power asymmetries that occur in provider-patient relationships. And finally, it is characterized by institutions that hold themselves accountable for generating these durable dispositions. Tervalon and Murray-García provide an example of the differences between cultural competence and cultural humility. They recall a Latina female Spanish-speaking patient who is complaining of excruciating pain after a surgical procedure. The patient is seen by an English-speaking doctor in the presence of a Latina nurse. The doctor is concerned about the patient’s pain. The nurse, however, replies that Latinas generally exaggerate their pain and that she is probably fine with the current level of pain medication. In this case, the nurse is presenting herself as culturally competent, but not as culturally humble. She is not disposed to learn from the patient, but rather assumes the patient is exaggerating. She is oblivious to the power imbalances that are present in the situation and fails to recognize that her representation of herself as a cultural expert undermines the patient’s legitimate request for additional pain medication. Finally, the institution is not accountable.
for the actions. The doctor simply agreed with the nurse without any further probing or exploration.

Having established a framework for understanding the relationship between language, health, and health care, we will now turn to an examination of Latino health in particular. We will explore the unifying threads that tie Latino health together and consider the place of *latinidad* as a centering idea in the umbrella concept of Latino health.

**Language, Latinidad, and Latino health**

The notion of Latinos as a single homogenous group emerged in the 1970s from a constellation of forces that were both imposed upon and emerged out of diverse communities. Politicians coveted what appeared to be a growing voting bloc and activists sought to gain civil rights victories by forming pan-ethnic coalitions. Beginning in the 1970s and into the 1980s, the U.S. Census Bureau introduced the pan-ethnic census category of “Hispanic” and media outlets began to emerge that would unify Latino communities through a common language – Spanish (Mora, 2014). These efforts of constructing a catch-all category that would place Spanish speakers and descendants of Spanish-speaking people under a single umbrella quickly spread to health research and health policy making. By the early 1990s, the focus on Latinos as a relevant grouping for public health analysis and intervention was well underway. In 1994, Marilyn Aguirre-Molina edited a groundbreaking volume *Latino Health in the U.S.A: A Growing Challenge* followed by *Health Issues in the Latino Community* in 2001 and *Latina Health in the United States: A Public Health Reader* in 2003. These early works brought into focus the work of multiple health researchers over several decades. As the editors note in the first chapter of the second volume in the trilogy: “the challenge before us is to consider the health of Latinos within the context of the demographic and social transformations that have begun and that will continue over the next several decades in the United States. Such a contextual analysis,” they continue, “can serve to inform policy as well as empower Latinos as the strengths and potential of this community are identified” (Falcón, Aguirre-Molina & Molina, 2001, p. 3). Even while the authors stress the demographic and social transformations affecting the Latino population – for example, the inclusion of emerging subgroups from Central America, the Caribbean, and South America – they continued to postulate Latinos as a single community undergoing internal transformations. A single-population optic, they proffered, would be the vehicle for favorable policy making from above and for ethnic empowerment from below.

Latino health can be understood as the combination of public health and health services research focusing on people of Latino descent. The large umbrella term provides the strategic advantages of numbers and growth that have the potential of garnering the attention of policy makers and funders while at the same time providing a mechanism for population内部 consciousness-raising, advocacy, and empowerment. As a field, however, Latino health has paid less attention to
the internal dynamics of *latinidad* that undergird and sustain a sense of pan-ethnic identification within the population itself. It has also only recently begun to bring into focus the “racializing” and “othering” processes that constitute Latinos as a population “at risk.” Both of these considerations are essential to our understanding of Latino health. The consciousness-raising, advocacy, and empowerment envisioned by Latino health scholars is properly rooted in conceptions of *latinidad*. The potential for meaningful policy development, on the other hand, must attend not only to in-group characteristics but also to the portrayal and apprehension of these characteristics by out-groups. In what follows, we will consider these two facets of *latinidad* in order to lay the groundwork for a consideration of the relationship between language and Latino health.

Jillian Baez (2007) argues for three different ways in which the concept of *latinidad* has been theorized. She argues for a political *latinidad*, a commodified *latinidad*, and a lived *latinidad*. Political *latinidad* is what she calls a strategic political alliance in which intragroup Latinos band together in order to achieve strategic objectives. She draws on the early work of Felix Padilla (1985) on intragroup Latino relations among Mexicans and Puerto Ricans in Chicago and his notion of a “Latino ethnic consciousness” to establish this theoretical orientation. Commodified *latinidad* is a second theorization that views the construction of a homogenous conceptualization of *latinidad* as rooted in market interests. Drawing on Arlene Dávila’s work on the construction of the “Hispanic market” (2001), she argues that the theoretical orientation of commodified *latinidad* essentially co-opts ethnic identification and erases cultural specificity and nuance. Commodified *latinidad*, according to Dávila (2000), equates language with Latino representativity and subsumes other cultural particularities. Finally, Baez identifies a third theorization that she calls lived *latinidad*. She draws on Mérida Rúa’s ethnographic work (2001) on the ways that ordinary people live into *latinidad* through daily negotiations of identity. Rúa sets out to show how *latinidad* is what Frances Aparicio called “an oppositional yet contested and multiply inflected marker of identity” (1999, p. 3). Rúa’s work uncovers “the agency of individuals in claiming transculturalized spaces such as PortoMex and MexiRicans, while recognizing the multiple tensions located in asserting such an identity for the individual” (2001, p. 123). She argues that people live into *latinidad* by negotiating and contesting essentializing practices through the deployment of multiple speech patterns, “crossing” over from one group to the other and “passing” as a member of one group rather than the other. People live into *latinidad* by engaging in transculturalized practices that draw flexibly from different social spaces. Lived *latinidad*, then, begins with “ordinary exchanges between Latinos of diverse ethnoracial backgrounds” (2001, p. 129). Each of these theorizations informs our understanding of the role of *latinidad* in the embodiment of health care and health disparities in Latino communities.

The theoretical orientation of political *latinidad* opens a first window into the intersection of *latinidad* and Latino health. Political *latinidad*, in fact, has been a salient force in activism around health equity and social justice in Latino populations. The unlawful firing of Magdalena García, a lab technician at Rush
Presbyterian St. Luke’s hospital in Chicago, is a case in point. Victoria Pérez, a colleague of García’s, recalls:

like other Latinos, she [Magdalena] was constantly pulled away from her job to translate. That’s how she began to see patient abuses. Many people didn’t know what was being done to them. They were just expected to sign the consent forms. The hospital administrators began to suspect that Magdalena was advising patients about their rights and didn’t like it. She was eventually fired because the hospital believed she could no longer be trusted.

(Pérez, 2011, p. 118)

García filed a lawsuit against the hospital under Title VII of the Civil Rights Act of 1964 arguing that her discharge was prompted in retaliation for her advocacy of Latino rights and assistance to other Latinos. The case was heard in U.S. District Court in 1978. The plaintiffs, moreover, defined Latino as any Spanish-surnamed person or individual of Hispanic ancestry residing in the city of Chicago. The formation of a political *latinidad* in this case brought attention to the mistreatment of all Latinos in the health system in Chicago at the time and accused it of systematic discrimination against its own employees who identified with this group.

Commodified *latinidad*, on the other hand, interfaces with Latino health in a different way. If political *latinidad* has served as a driver of activism and advocacy in opposition to mainstream health services, commodified *latinidad* has provided a vehicle to bring *latinidad* into the mainstream. Researchers studying health outcomes in Latino populations have long confronted what seems to be a paradox – while Latino populations demonstrate lower socioeconomic status and less access to health care, their health outcomes appear to be better than those with higher socioeconomic status and greater access. This finding has come to be known as the Latino epidemiological paradox. In 2007, the New York Times published a vivid portrayal of the paradox highlighting the longer-than-expected life span of Latino immigrants: “If medical researchers were to pick someone who might defy national life expectancy statistics,” the author writes, “few would pick Irma Lara” (Kolata, 2007). The author of the piece goes on to describe Mrs. Lara as a 75-year old widow who emigrated to Texas from Mexico, had seven children, and lived on the meager salary of cotton compress company worker. Mrs. Lara, according to the article, is still poor, living on only $600 per month. Even so, Mrs. Lara’s life expectancy is thought to be greater than a similarly situated non-Hispanic white or African American female. Numerous hypotheses have been proffered to account for this paradox. The salmon-bias hypothesis, for example, posits that immigrants tend to return to their countries of origin to die, therefore disappearing from the mortality statistics and creating an illusion of greater longevity. Another hypothesis, known as the healthy migrant effect, posits that the mortality statistics are skewed because only the healthiest people choose to migrate. Unhealthy people choose to remain in the country of origin, thus introducing a selection bias in the population. Studies have found, however, that these hypotheses do not fully explain the mortality statistics. Life expectancy is not the only indicator that
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has puzzled researchers. Birthweight is also a health statistic that has confounded researchers. Latina women tend to have better than expected delivery outcomes as revealed by birthweight statistics. In 2017, the national average of low birthweight deliveries as a percent of all births stood at 8.3%. While African American women accounted for the highest low birthweight deliveries at 13.6%, Hispanic women accounted for only 7.4% – a figure that is much closer to the 7.0% rate of non-Hispanic whites than to African Americans (CDC, 2018). Alyshia Galvez (2011) conducted an ethnographic study of Mexican immigrant women in New York City to uncover the potential factors that contribute to the lower than expected low birthweight statistics. Her findings reveal that cultural approaches to prenatal care may be a contributing factor to the low birthweight phenomenon among Mexican immigrants. She argues that many women bring with them traditional prenatal care practices from previous deliveries in Mexico and that these practices might produce a health protective effect. In fact, Galvez’s findings echo a theme that has been resounding in scholarly approaches to the paradox for some time. Researchers have hypothesized that perhaps the cultural practices of immigrants – devotion to family, a collectivist orientation, cultivation of spirituality – provide health protective benefits that neutralize the benefits that accrue to nonimmigrant via socioeconomic indicators. This focus on “culture as cure” (cf. Santiago-Irrizary, 2001) has led some researchers to view the discussion of the Latino epidemiological paradox as an element of the commodified discourse surrounding latinidad. “The popular usage of the Latino paradox,” Arlene Dávila argues, “renders Latinos as the only group whose health is seemingly buffered by their culture” (2008, p. 2). Dávila suggests that the Latino paradox converges on a larger discourse, what she calls “Latino spin,” that reconstitutes Latinos as a marketable segment of the population. The theoretical orientation of commodified latinidad, then, provides another window into how latinidad intersects with Latino health.

The theoretical orientation of lived latinidad opens a third window on the intersection of latinidad and Latino health. This orientation brings into focus the perspective of Latinos as they engage with the health system. Lived latinidad provides a framework for understanding the complex negotiations that take place as Latinos interact with a dominant culture health system and with each other in that context. As David Hayes-Bautista argues:

> when a pregnant Latina avoids going out during a full moon, gives up the pleasures of gum chewing, wears a red thread around her abdomen, and yet wants to see her sonogram and practice Lamaze techniques, she embodies the continuity and change that characterize Latino culture.

(2008, p. 6)

Engagement with the health system provokes a flexibility and a hybridity in which disparate cultural forms and practices are negotiated and combined in different ways. In one sense, then, latinidad comes to be expressed through these varied combinations. In another sense, however, expressions of latinidad in health care encounters can be assessed through the identities and identifications of
different Latino subgroups in clinical encounters. David Hayes-Bautista and Roberto Chiprut demonstrate the lived experience of pan-ethnic identities and identifications in health care settings in their book *The Art of Healing Latinos: Firsthand accounts from physicians and other health advocates*. In this book, the editors collect testimonial accounts of Latino health care providers who reflect on their encounters with Latino patients. The testimonial genre offers unique insights into the perspectives of health care providers from multiple backgrounds highlighting the ways that they identify with the culture of their patients. Cuban-born physician Felipe Santana, for example, describes his connection with Mexican immigrant patients in a community mental health clinic in southern California. He writes:

In the second week at Clínicas, the experience of American professional life fell away, and I returned to my roots. Everything became clear to me. Everything made sense. I was present with my patients. I began to utilize the appropriate cultural tools. I did not need to begin by asking questions. I did not need to be systematic. I was able to learn what I needed through a conversation, during which almost all the information was revealed without my prompting. This method, developed through my experience, was both profound and simple.

(Santana, 2008, p. 26)

Lived *latinidad* is thus manifested through these wider pan-ethnic cultural identifications. Another way in which lived *latinidad* is evinced is through advocacy for Latino patients. América Bracho, a Venezuelan health promoter and director of Latino Health Access in Orange County, California – an award-winning diabetes education program – recalls her advocacy efforts when she was informed that one of her diabetes participants had suddenly gone blind. “In talking with her health provider,” Bracho writes,

I discovered that diabetics weren’t receiving eye examinations annually because the clinic simply didn’t believe the patients could manage the treatment of these sorts of complications. I felt frustrated. This condescending attitude correlated with so many others I had witnessed in which patients have not been informed of their problems because it was assumed that they were incapable of being part of the solution. And when the patients are low-income Latinos, the attitudes are even worse.

(Bracho, 2008, p. 77)

Bracho goes on to describe how she immediately included a module on eye care in her diabetes education curriculum. These examples underscore the role that *latinidad* can play in health care encounters as a transcultural negotiation both between the home culture and biomedical culture as well as between pan-ethnic providers and patients.

These three theoretical orientations to *latinidad* – political *latinidad*, commodified *latinidad*, and lived *latinidad* – speak to the in-group characteristics that shape
the experience of health care for Latino populations. But out-group characteristics also play a role in shaping this experience. The “racialization” and “othering” processes that affect Latinos are deep and have been far-reaching. The racialization of Mexicans is a well-documented process that goes back to the initial contacts between Anglos and Mexicans in the nineteenth century (cf. De León, 1983). At the dawn of the twentieth century, propelled by the mass movement of people from Mexico to the U.S. southwest fleeing the violence of the Mexican Revolution, the racialization processes intensified. Carey McWilliams describes an emerging discourse around the so-called “Mexican problem” between 1920 and 1930 (1968, p. 206). Discourse about the Mexican problem focused on the threat of Mexicans to the social fabric of the United States through high rates of delinquency, unsanitary living conditions, illiteracy, and infectious disease. The presence of Mexicans in the United States was thus portrayed as a public health threat. Chicago physician Benjamin Goldberg expressed the view of Mexicans as a public health threat concisely in his 1929 article in the *American Journal of Public Health*:

The Mexican of tomorrow will bring to our towns and cities dangers which will strain the resources of the local and national public health agencies to the utmost. We have discussed the subject of tuberculosis in primitive races merely to bring out the ravages among the Mexicans as they go through the process of urbanization. We have tried to indicate that in this process the Mexican will not be like the Indian, for he will not suffer alone; he will be infected and in turn will broadcast tuberculosis in the community.

(Goldberg, 1929, p. 278)

The public health response to the perceived threat posed by the presence of Mexicans was to be found in population control measures through either deportation or fertility control. In what follows, we will discuss each of these mechanisms separately; however, it is worth noting at the outset that the mechanisms were open to broad interpretations that quickly spread from a singular focus on Mexicans to a wider focus on Latinos.

Deportation and deportability have been key concepts in the production of Mexicans and other Latinos as undesirable and unfit members of the polity. Deportation highlights the power of the state to exert control over its boundaries by forcibly removing and effectively erasing those that it deems undesirable or threatening. It is a powerful mechanism of population control that has been wielded against Latino populations, communities, and families for decades. In the 1930s, for example, the U.S. government unleashed this mechanism in an unprecedented way. Between 1929 and 1936, anywhere from 400,000 to 2,000,000 Mexicans were forcibly removed from the country in response to the concomitant forces of anti-Mexican hysteria and the Great Depression. It is estimated that up to 60% of those forcibly removed were birthright citizens of the United States (Balderrama & Rodríguez, 2006). People of Mexican origin were stripped from their families and their possessions, loaded up on trains and sent to a country that
they did not know. The public health system was an integral part of the effort to identify, locate, and deport Mexicans. In Los Angeles, for example, the responsibility for identifying candidates for repatriation was located in the Deportation Section of the Los Angeles County Department of Charities – the entity responsible for all public medical facilities in the county. The mission of the deportation section was “to identify and then deport any undocumented Mexican receiving county-sponsored medical aid” (Molina, 2006, p. 136). According to Molina, this single deportation section was responsible for deporting over thirteen thousand Mexicans between 1931 and 1933.

But the role of public health in carrying out deportation was not limited to the implementation of the mass repatriation of Mexicans in the 1930s. On the contrary, public health’s role in deportation has been codified in immigration law, making medical diagnosis a singularly potent criterion for deportability. The Immigration Act of 1891 defines the condition of “likely to become a public charge” (LPC) as grounds for deportation. “Any alien who becomes a public charge within one year after his arrival in the United States from causes existing prior to his landing therein shall be deemed to have come in violation of law and shall be returned as foresaid” (cited in Molina, 2014, p. 92). By 1917, the LPC grounds had been extended from 1 year to 5 years. LPC, then, became permanent grounds for deportation and was utilized to target undesirable immigrants. As Molina notes:

> The strategy was foolproof. Migrant laborers’ poor working and living conditions made them more vulnerable to disease, and the high population of single, male migrant workers and workers separated from their families increased the likelihood of the presence of sexually transmitted diseases in particular. Hence, Mexicans were always suspended in the state of deportability. (Molina, 2014, p. 109)

Deportability, as a mechanism of population control, has been accompanied by another mechanism – fertility control. The concerns over Mexican immigration emerging in the 1920s continued unabated throughout the twentieth century. As Alexandra Stern has shown in her book _Eugenic Nation: Faults and frontiers of better breeding in modern America_, immigration concerns had long been tied to eugenic views on population control. Coined by Sir Francis Galton, the term eugenics refers to what Davenport called in 1911 the “science of the improvement of the human race by better breeding” (cited in Stern, 2016, p. 11). The eugenic underbelly of anti-immigrant sentiment was manifested more fully in the 1960s when anti-immigrant sentiment converged with growing concerns around the impact of overpopulation on the planet and on humanity itself. Stanford University professor Paul Ehrlich published his book _The Population Bomb_ in 1968 warning of mass starvation and major societal upheaval if population growth was not curtailed. His work, although severely criticized for its alarmist tone, sparked a move towards zero population growth (a situation in which the natality rate was equal to the mortality rate). The convergence of these two discourses brought into focus not just the “illegal” presence of Mexicans in the United States but also
their higher-than-average fertility rate. Fertility control thus came to be a sinister cousin of deportation and deportability. Leo Chavez sums up the concern over Mexican fertility in the U.S.: “in the final analysis, the discourse surrounding Latina fertility and reproduction is actually about more than reproduction. It is also about reinforcing a characterization of whites as the legitimate Americans who are being supplanted demographically by less-legitimate Latinos” (2008, p. 110). The same concerns that motivated deportation were also the driving force of fertility control. Coercive sterilization was the method of choice to enact fertility control.

In her book *Fertile Matters: The politics of Mexican-origin women’s reproduction*, Elena Gutiérrez documents the pattern of coercive sterilization that emerged in Los Angeles during the mid-twentieth century leading up to the landmark case *Madrigal vs. Quiligan*. The Madrigal case was a complaint by ten women who had been sterilized without proper consent at the Los Angeles County Medical Center. The complaint alleged that Mexican women were sterilized at higher rates than non-Mexican women and that they were coerced into consent by multiple means, such as being told that their babies would die if they failed to consent, having pain medication withheld, or simply being told “sign here.” The impact of sterilization on the lives of the plaintiffs was profound. It thrust some women into severe depression, led to marital strife and even drove some women to want to commit suicide. While the court case ultimately did not lead to a legal victory, it did prompt policy changes such as a mandate to provide informed consent forms in Spanish and a mandatory 72-hour waiting period in cases of informed consent for tubal ligations (Gutierrez, 2008).

Coercive sterilization was not only exacted on Mexican women but was also a common practice in Puerto Rico beginning in the late 1930s until well into the 1970s. In the Puerto Rican case, the motive for coercive sterilization was the soaring unemployment rate on the island as a consequence of industrialization. The U.S. government implemented a series of campaigns promoting the ideal family size as an imperative of modernization. And while the kinds of abuses documented in California were not present in Puerto Rico, the common theme among sterilized Puerto Rican women was that they thought it was a reversible procedure. Coercive sterilization quickly became a hot-button political issue tied to the larger issue of the political status of the island. These concerns spread to mainland Puerto Rican advocacy groups such as the Young Lords. As Laura Briggs notes: “mainland-born youth in their late teens and early twenties were inspired by mainland racial justice movements, the legacy of Albizu, and the insular independence movement. They adopted the pro-natalist, anti-sterilization rhetoric” (2002, p. 152).

Deportation and fertility control were thus tied together as twin engines that fueled the policy response to what Leo Chavez has called the discourse of “Latino threat.” In doing so, they also blurred and erased the cultural nuances of the different Latino origin subgroups and strengthened the representation of Latinos as a single homogenous and undesirable group. By placing Latinos within a “Latino threat” narrative “the objects of this discourse are represented as the Other and
as a ‘threat’ and ‘danger’ to the nation through such simple binaries of citizen/foreigner, real Americans/Mexicans or real Americans/Hispanics, natives/enemies, us/them, and legitimate/illegal” (Chavez, 2008, p. 41). This dimension of racialization and othering is a powerful force in Latino health. Recent research has sought to explore the impact of othering on health by proposing that

the processes whereby immigrants and their descendants ‘become American’ involve more than behavioral norm-swapping, as simple conceptualization and interpretations of acculturation would lead us to believe. Rather, these processes entail learning and interpreting the racial dynamics of the U.S. and finding one’s location within it.

(Viruell-Fuentes, 2007, p. 1533)

When I talk about Latino health, then, I am not referring simply to public health and health services research that focuses on Latino populations. On the contrary, Latino health brings into focus not only the internal dynamics of intra-ethnic identification and identity within the health care context but also the effect of larger racialization and othering processes that affect Latinos as a collective whole. In what follows, we will explore the intersection of this specific understanding of Latino health with the use of Spanish in health care settings.

Language and Latino health: from social determinant to syndemic

The empirical study of the impact of Spanish language preference and use in Latino populations has evolved considerably over the past two decades. In this section, we will consider the major thrust and evolution of this empirical research, identify gaps, and propose alternative theoretical insights that may provide new understandings of the place of Spanish in Latino health. Early studies focused on Spanish language preference as a stable dichotomous (Spanish vs. English) or trichotomous (Spanish vs. Spanish/English vs. English) variable that sheds light on patterns of disease distribution or access to care.

Rooted in social epidemiology, a subfield of epidemiology that seeks to uncover the influence of social circumstances on health, these studies viewed Spanish language preference, use and/or proficiency as a social determinant of health. Social determinants of health can be viewed as causes of illness or wellness. For example, we have typically understood causes such as a diet high in saturated fat and salt as a risk factor of the ultimate outcome, i.e., heart attack. Social determinants take a step back and consider the reasons why some people are more likely than others to consume this type of high-risk diet. As Michael Marmot has noted: “it is not an accident that people consume diets high in saturated fat and salt. It represents the nature of the food supply, culture, affordability, and availability, among other influences” (Marmot, 2006, p. 3). These more distal influences then are viewed as social determinants of health. Figure 1.1 visually represents the concept of social determinants of health.
This visual representation highlights a uni-directional influence wherein social structure (in the upper left-hand corner) impacts well-being, morbidity, and mortality (in the lower right-hand corner). The pathways of influence can be either material (as seen in the direct line going from social structure to well-being, morbidity, and mortality) or they can be mediating influences in the form of early life experiences, genetic disposition, or cultural factors (which all mediate some part of the model). In the center of the diagram, furthermore, we see a complex chain of causation that takes us from social structure through either work experience or the social environment. These two factors in turn may influence both health behaviors and psychological factors. Psychological factors have a direct impact on the brain and both the brain and psychological factors may influence health behaviors (as noted in the dual-headed arrows). Finally, factors in the brain and in health behaviors influence pathological changes which then ultimately lead to well-being, morbidity or mortality.

Studies of Latino health that consider language as a social determinant of health can be sorted into those that look at language preference, use, or proficiency of the patient as a factor influencing health outcomes, and those that look at the impact of language concordance between provider and patient. Studies focusing on
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language preference, use, or proficiency have identified outcome factors related to both access to care and specific health outcomes. These studies provide conclusive evidence that Spanish-language preference, use, and proficiency are associated with limited access to health service and with less than optimal health outcomes.

Studies have examined the impact of Spanish language preference, use, or proficiency on access to health services. Access-oriented studies have focused on cancer screening, on receipt of recommended care, and on health literacy. Jacobs et al. (2005), for example, found that women who only spoke a language other than English had a lower likelihood of cancer screening than women who spoke English. Cheng, Chen, and Cunningham (2007), on the other hand, focused on patient receipt of eligible health care services by Latino and white patients using data from the Medical Expenditure Panel Survey of 2003. They compared white patients with Latino patients who spoke English at home, Latino patients who did not speak English at home but were comfortable speaking English, and Latinos who did not speak English at home and were not comfortable speaking English. While 53.6% of Latinos who spoke English at home received all eligible health care services, only 35% of Latinos who did not speak English at home and were not comfortable speaking English received these services. Jacobson, Hund, and Soto Mas (2016) focused on health literacy as a measure of access. The Institute of Medicine defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (IOM, 2004). The authors found that English proficiency was the strongest predictor of health literacy.

Outcome-oriented studies point to disparities in the results of care and have focused on vaccination, participation in health-promoting lifestyle activities, length of hospital stays, and informed consent. A study of influenza vaccination among Latino seniors in the southeast of the U.S., for example, found that Spanish-prefering and linguistically isolated seniors were far more likely to have lower rates of vaccination than non-Hispanic whites (Haviland et al., 2011). Another outcome-oriented study focused on participation in health-promoting lifestyle activities among Spanish-speaking Latinos in Nebraska and Iowa— including healthy eating, participation in physical activity, stress management, and spiritual growth behaviors. Latinos were grouped in three language-based strata: 1) those who spoke Spanish only, 2) those who spoke Spanish more than English, and 3) those who spoke both languages equally. The findings revealed that those who spoke Spanish only were least likely to participate in health-promoting lifestyle activities, followed by those who spoke Spanish more than English. Those who spoke both languages equally were the most likely to participate in these activities. The authors thus concluded that English language proficiency and use increases participation in health-promoting lifestyle behaviors (Hulme et al., 2003). Hospital-based studies have also focused on outcomes. For example, a study of length of hospital stays compared limited English proficient (LEP) patients with English proficient (EP) patients and found that LEP patients stay in the hospital 6% longer than EP patients (John-Baptiste, 2004). Another hospital-based study examined the documentation of informed consent for common invasive procedures among
LEP and EP patients. This study found that EP patients were three times more likely than LEP patients to have full informed consent documentation in the medical record (Schenker et al., 2007).

Studies of language concordance seek to elucidate the effects of receiving care from a Spanish-speaking provider. Language concordant care occurs when a Spanish-speaking patient is seen by a provider who also speaks Spanish. Language discordant care occurs when a Spanish-speaking patient is seen by a provider who does not speak Spanish. Language concordance studies with Latino populations have focused on specific health outcomes, on the quality of care, and on intersubjective processes in the health care encounter.

Outcomes-oriented studies have focused on the influence of language concordance on glycemic control among Spanish-speaking patients with diabetes. Spanish-speaking patients with diabetes who receive language discordant care are almost twice as likely to have poor glycemic control in comparison to English-speaking patients, while those who receive language concordant care are more similar to English-speaking patients (Fernandez et al., 2011). A follow-up study was conducted to confirm these findings and further underscore the impact of language concordance on diabetes management. The study set out to determine the impact on glycemic and cholesterol (LDL) control when a Spanish-speaking patient with diabetes switched from a language discordant physician to a language concordant physician. Among patients who switched physicians, there was a 10% increase in glycemic control and a 15% increase in LDL control (Parker et al., 2017). Other outcomes-oriented studies have focused on the role of language concordance in promoting medication adherence. A study examining adherence of Spanish-speaking patients to cardiovascular disease medication found that patients with language concordant physicians were 6% more likely than patients with language discordant physicians to adhere to their medication regimen (Traylor et al., 2010). Another study on medication adherence evaluated the effect of language concordant prescription medication instructions. This study demonstrated that patients who received language concordant instructions demonstrated greater understanding of their medication and its dosing (Bailey et al., 2012). These outcome-oriented studies demonstrate that language concordant care has clinically relevant implications for Spanish-speaking patients.

Language concordance studies have also focused on quality of health care investigating measures such as patient satisfaction, timeliness of care, and hospital discharge processes. A study of foreign-born, limited-English-proficient Latino patients drawn from the Latino Health Survey indicated that these patients were more likely to self-report clinical experiences as confusing, frustrating, and of poor quality. The study set out to determine if patients receiving language concordant care were more or less likely to self-report these experiences. The findings revealed that patients with language concordant physicians were less likely to report confusion, frustration or poor quality in comparison to patients with language discordant physicians. The authors conclude that while English language proficiency is important in receiving quality care, the fact that the patient and the doctor speak the same language seems to be a more important determinant of
quality care (González, Vega & Tarraf, 2010). Another study indicated that while language concordance in general drives patient satisfaction, patients were more satisfied when their providers spoke Spanish fluently (Eskes et al., 2013).

Finally, language concordance studies have measured intersubjective processes such as agreement with physician recommendations, number of questions asked, trust and rapport, and perceptions of discrimination. These intersubjective-oriented studies also point to the advantages of language concordant care. A study that examined physician-patient agreement about physician recommendations for health behaviors found that patients with language concordant physicians were more likely to agree with their physician’s recommendations about exercising than those with language discordant physicians (Clark, Sleath & Rubin, 2004). Another study examined the influence of language concordance on interpersonal care as a function of communication, decision-making, and interpersonal style. Patients with language concordant physicians, in comparison to patients with language discordant physicians, were less likely to perceive lack of clarity in physician communication and more likely to indicate that the doctor elicited concerns and explained results. Patients with language concordant physicians were also more likely to indicate that decisions were made together in comparison to patients with language discordant physicians (Detz et al., 2014). Patients’ improved perceptions of interpersonal care with language concordant physicians has also been shown to impact the number of questions that patients tend to ask. Language concordant care increases the number of patient-asked questions during a visit (Jaramillo et al., 2016). This outcome of language concordant care reflects a broader impact in the trust and rapport established between Spanish-speaking patients and their language concordant physicians. A study of clinical interactions among patients with diabetes, for example, found that patients with language discordant physicians were significantly more likely to lack confidence and trust in their physician and to feel treated poorly and disrespected by physicians in comparison to patients with language concordant physicians (Schenker et al., 2010). A study on the effects of language concordance and interpreter use on the therapeutic alliance in behavioral health found that patients felt that language concordant encounters were more efficient, more effective, more confidential, and easier for the establishment of trust and rapport. Patients in the study who had language concordant providers also indicated that they were more willing to disclose sensitive information when interacting with a language concordant provider as opposed to when they were interacting through an interpreter (Villalobos et al., 2016).

Together these studies establish language as a social determinant of health. They show that Spanish-language preference, use, and proficiency have a measurable impact on access to services and on health outcomes. Further, they suggest that the presence of language concordant providers improves health outcomes, quality of care, and intersubjective processes. Recent research, however, has begun to push the boundaries of these associations. For example, researchers are beginning to question how Spanish-language preference, use, and proficiency interact with other known social determinants of health. They are also questioning
the influence of intersubjective processes beyond the language concordant health care encounter.

Studies that seek to shed light on the interactions between language and other social determinants are beginning to uncover heretofore unnoticed connections. For example, researchers are beginning to look at mediating factors that might affect the relationship between language and health, including racial identification (Cuevas, Dawson & Williams, 2016) and place of origin (Abraido-Lanza, 2015). As Abraido-Lanza points out: “Latino groups differ in sociopolitical histories and reasons for migrating to the United States. Moreover, the context of reception in the United States differs for the various groups and at different points as a result of economic conditions, labor shortages, and the political climate” (Abraido-Lanza, 2015, p. 567). These differential contexts can shape the ways that language interacts with health. Economic conditions, labor shortages, and the political climate can significantly reduce the frequency of contact between Spanish speakers and health and social service agencies. Other studies are zeroing in on “post-migration perceived social mobility” as a factor that interacts with language. These studies focus on the perception of upward or downward mobility as a function of migration. An examination of data drawn from the National Latino and Asian American Study found that major depressive events were positively correlated with perceptions of post-migration downward mobility (Alcántara, Chen & Alegría, 2014). Together these studies appear to suggest that social determinants, including language, may be relative to the contexts in which they emerge and may be dependent upon previous experiences. As Hsieh (2017) has pointed out:

language discordance is situated in the complex tension of political power and linguistic legitimacy . . . an under-theorized and under-synthesized area of research on LEP patients is the various factors that may serve as mediating and moderating factors for language discordant patients’ experiences in health care settings.

(p. 3)

In addition to questions about the interactions and situatedness of language and other social determinants, researchers are also beginning to focus on issues of intersubjectivity beyond the clinical encounter. How do wider intersubjective processes influence health outcomes and health care access? A study of health beliefs, health promotion practices, past health care experiences, and transition to a new society and health care system among 20 Latina women in Utah found that women expressed feelings of aloneness in seeking health care. The women in this study recalled that, in their home countries, illness was handled in a more social way. One of the women in the study confided: “I feel that I could not defend myself in this country” (Sanchez-Birkhead et al., 2011, p. 1170). A study of language barriers among Latina mothers in Detroit and Baltimore revealed similar findings. Mothers described managing language barriers as a “battle” and expressed a preference for bilingual providers, negative bias towards interpreters, getting by with limited language skills, fear of being a burden, and stigma and discrimination
(Steinberg et al., 2016). A review of coping strategies among Latino caregivers of children with chronic illnesses found that language, cultural dissimilarities, differences in health beliefs, and feeling disrespected were common challenges. Sources of support among lower income recent immigrants with limited English proficiency were principally from the family. Feelings of isolation, furthermore, were more pronounced and emerged from having a significantly smaller social network (Desai, Torres-Rivera & Backes, 2016). Viruell-Fuentes and Schultz (2009) probed the issue of social ties further in their study of first- and second-generation Mexican women in Detroit. They argue that networks are less culturally determined and more responsive to the contexts in which they emerge. For example, they demonstrate that first-generation women found a great deal of support in family members upon arrival but that this support withered away as family members faced their own challenges. Second-generation women, on the other hand, emphasized the racialized context of social ties and the importance of identity supports that would foster a positive ethnic identity. First- and second-generation women thus faced different challenges in establishing and maintaining social ties. First-generation women experienced eroding support from family members and increasing isolation. Second-generation women experienced “othering” processes and identity erosion in a racialized context. Together these studies underscore the impact of wider intersubjective processes on health outcomes and health care access. Feelings of aloneness and isolation, lack of social support, struggles for access, and othering all place Latinas/os at risk of diminishing emotional health.

These new directions in research on language as a social determinant of health suggest the need for a different “idiom of social justice mobilization” when discussing the relationship of Spanish to Latino health (Willen, Abadía-Barrera & Davidovitch, 2017). Studies on the interactions of language and other social determinants suggest that the effects of Spanish-language preference, use, and proficiency are situated and contextual. Studies on the wider intersubjective processes affecting Spanish speakers suggest that language barriers interact with emotionally debilitating experiences both within the health care setting and beyond it. What these approaches have in common is their insistence on viewing language as couched in a larger set of processes that impact health outcomes and health care access. The social determinant model, however, has difficulty capturing the embeddedness and intersectionality of language with other social determinants, wider intersubjective processes and, many times, multi-morbid physical and mental health conditions. The unidirectional nature of the model and its bias towards causation as opposed to interaction leads us to question its ability to adequately capture the multilayered and complex relationship between Spanish and Latino health.

Syndemic theory is an alternative way to conceptualize the relationship between Spanish and Latino health. Syndemic is an idiom of social justice mobilization for health that values the complexity of interacting social factors and that looks beyond disease causation to focus instead on the varying experiences of living with disease. Rooted in medical anthropology, syndemic theory arose out of concerns around medical comorbidities and the social factors that interact...
with comorbid conditions. Merrill Singer coined the term syndemic as a blend of the words “synergy” and “epidemic” to express the dominant focus of the approach on synergies in disease states. The concept emerged from Singer’s work among HIV-AIDS patients in Connecticut. He found that most HIV-AIDS interventions were designed primarily with middle-class, white, homosexual men in mind. These interventions were of little use in his work where he encountered HIV-AIDS patients who not only did not match the demographic bias, but also who were experiencing other conditions together with HIV-AIDS, namely substance abuse and violence. He thus set out to explore the experience of living with AIDS in conjunction with substance abuse and violence and characterized his work as focusing on the SAVA (Substance Abuse, Violence, AIDS) syndemic. He defines the term syndemic as “the concentration and deleterious interaction of two or more diseases or other health conditions in a population, especially as a consequence of social inequity and the unjust exercise of power” (Singer, 2009, p. xv).

More than a model or a theory, syndemic can be described as a sensibility; a sensibility that expands, enriches, and reframes our understanding of complex situations of health adversity (Willen, Abadía-Barrera & Davidovitch, 2017). Viewing health adversity with a syndemic sensibility allows us to:

1) Recognize how upstream factors create and perpetuate structural vulnerabilities that contribute to syndemic emergence and exacerbation; 2) to understand and describe how certain individuals, families, and communities but not others are consigned to harmful environments of syndemic vulnerability with concrete effects, and 3) to intervene more effectively both upstream in the domains of civil society, law, policy, and public health practice and downstream at the point of clinical contact.

(Willen, Abadía-Barrera & Davidovitch, 2017, p. 968)

In this way, a syndemic sensibility moves us away from a focus on causation and invites us to focus instead on interaction. Figure 1.2, describing a syndemic model of substance abuse, intimate partner violence, HIV infection, and mental health conditions among Latinos, visually represents the distinctive features of the syndemic perspective.

In Figure 1.2, the cross-shaped figure represents the syndemic interaction of the four identified health conditions. The circles represent upstream social factors that influence the four-pronged syndemic interaction including individual factors, cultural factors, relationship factors and socio-environmental factors. These factors not only interact with the comorbid conditions identified in the syndemic, but they also interact with each other as represented in the dual-headed arrows linking each circle.

The syndemic perspective has been profitably applied to Latino health. Emily Mendenhall (2012) describes the VIDDA syndemic affecting Mexican immigrant women in Chicago. The VIDDA syndemic analyzes the interactions between violence, immigration/isolation, depression, diabetes, and abuse. Her analysis of
the syndemic draws on the life stories of women whose biographies personify the complex interactions and interrelatedness of experiences such as childhood trauma, struggles for social integration, sexual coercion and violence, family stress, depression, and the everyday stresses of managing diabetes. She demonstrates how structural factors such as food deserts, unsafe neighborhoods, and discrimination interact with sociocultural factors such as acculturation and gender roles, which in turn interact with individual factors such as childhood experiences and coping mechanisms and with relationship factors such as family conflict and social support in order to create an excess burden of diabetes, depression, immigration, violence, and abuse. Sarah Bronwen Horton (2016) describes a syndemic of heat stroke and kidney disease among farmworkers in California’s Central Valley abetted by structural factors such lack of labor protections for agricultural workers and undocumented status. González-Guarda, Florom-Smith and Thomas (2011), González-Guarda et al. (2016) describes a syndemic of substance abuse,

![Figure 1.2 A Syndemic model of substance abuse, intimate partner violence, HIV infection and mental health conditions among Hispanics. Source: González-Guarda et. al. 2011, p. 368; Reproduced with permission of John Wiley and Sons, Ltd by PLSclear](image-url)
intimate partner violence, HIV, and mental health among Latino men. They argue that cultural factors such as immigration-related stress and adherence to cultural values such as familismo, machismo, and marianismo, and the influence of religion may all serve to link syndemic conditions. While these factors may contribute to an excessive burden of disease in some cases, in other cases cultural factors may also be health protective. For example, the cultural value of familismo can be an important protective factor when families accept and support children identifying with a minority sexual orientation.

The application of a syndemic sensibility has the potential of considerably advancing our understanding of the relationship of Spanish and Latino health. It invites us to contextualize Spanish-language preference, use, and proficiency in ways that previous studies have overlooked. Further, it invites us to adopt a more granular perspective on language concordant encounters. A syndemic sensibility in the study of Spanish and Latino health, moreover, can open up new lines of research. For instance, how do life-course events and experiences shape and contribute to syndemic production? What role do childhood or recent immigrant experiences of linguistic othering play in the burden of disease within Latino populations? Questions such as these will open our research purview to language experiences that are currently invisible to us.

And this brings us full circle to Maribel Garza. Her story is one of multiple conditions, all interacting with each other and increasing the burden of disease, changing the experience of disease. I think we owe it to Maribel Garza to expand our questioning and to strive to truly understand her plight. Only in this way can we begin to lighten her load and get to that “one day” that drives her.

References


Language and Latino Health


Office of Minority Health. (2013). *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and


References

1 Sight translation is one of the three modes of interpreting, together with consecutive interpreting and simultaneous interpreting. In consecutive interpreting, the interpreter mediates after each conversational turn. In simultaneous interpreting, the interpreter speaks at the same time as the interlocutor. In sight translation, the interpreter reads a text written in one language aloud in the other language.

1 Patient acuity refers to the severity of illness. Acuity scores are used to determine the number of patients who can be seen at any given time relative to the nurses on staff. A lower acuity score thus results in longer wait times in hospital emergency rooms.

1 Javier Mauricio Cepeda is my father and he is 52 years old. My father means everything to me. It is because of him that I am what I am today. He was born in Mainero, Tamaulipas and he immigrated to the United States when he was a teenager in order to help his father. His mother passed away when he was only two years old. In the summer of 2011, a week after we returned from Villagrán, Tamaulipas to Sebastian, Texas for our vacation, my father began complaining about a headache. My dad is a very stubborn man. He answers even before a question is asked. He doesn’t like to be told what to do. He would say: “it’ll go away. I already took a pill.” It seemed like he said this simply to get us to stop bothering him. My dad refused to go to the hospital even though we kept insisting. The language barrier was one of the reasons my dad avoided the hospital. He felt that they wouldn’t help him anyway and he would say – “I’m fine. What’s the doctor going to do anyway? I don’t have money to be paying doctors.” He would complain but he never let us see him when he writhed in pain. Then my sister Marisol said: “enough is enough; I am taking you to the hospital.” My sister picked us up in Sebastian and we went to Valley Baptist Medical Center in Harlingen, Texas.

My father Javier, my mother Francisca, my sister Marisol and I were fretting during the entire trip. We feared the worst. That half hour trip from our house to the hospital felt like the longest trip of our lives. I prayed the whole way that my dad’s problem would not be that severe. I asked the Virgin of Guadalupe: “Virgencita, Madre mía, te ruego y te imploro que por tu divina ayuda no desampares a mi papi en estos momentos.” That day, August 9, 2012, was the day that would change our lives forever. Marisol went with my dad into the emergency room because he doesn’t speak English – it’s not like he needs it working on the farms – and she was his interpreter. Marisol sent me a text message telling me: “Don’t be afraid but make sure not to upset mom; she also has a heart condition.” As soon as I read this I knew that something was seriously wrong. I kept reading. Marisol wrote: “dad has bleeding in his brain. Tell mom but make sure that she doesn’t get upset. Tell her that dad will be fine.” My eyes watered and I had to tell my mom that the man she had been married to for 31 years was bleeding in his brain. “Cerebral hematoma,” that’s what the doctor’s called it. This made my dad sleep all the time and caused severe headaches. Later they moved him to the intensive care unit and there a long process of tears, sadness, prayer, and faith began.

My dad did not want to go to the hospital because he didn’t know any English other than “good morning” and “thank you.” My sisters and I were his translators. My mom would stay with him day and night. My sister and I would take turns staying so that she could go home and rest. It was hard. It was hard because when the doctors and nurses would come to take my father for tests it was in the middle of the night and my mom had to communicate with them through gestures. They would only allow one person in the room at a time and my mom didn’t know English. The language barrier notwithstanding, the medical personnel was good. After my father’s first surgery, he was recovering well. But a few days later, he passed out and would not wake up. The doctors didn’t know why so they operated on him again because he continued to bleed. After the second surgery things appeared to be stable but it turned out that he had an infection so they operated on him a third time. Some days my dad would be fine; other days, not so much. Some days he would lose control of the left side of his body; other days he would lose control
of the right side. The doctors would tell us that my father’s condition was rare – that it was something they had never seen. They were at a loss to explain my dad’s condition. They kept asking if he had hit his head, and my dad kept responding that he had not. Then the doctors asked us, and we said the same thing: he had not hit his head. They couldn’t understand what may have caused the bleeding. If they didn’t know, we didn’t know either; my dad never told us anything.

He was placed in rehabilitation to recover the muscle strength that he had lost while in the hospital. He received speech therapy because some days we just couldn’t understand what he was saying. In the autumn of 2011 I didn’t go back to school. I stayed in my parent’s home to help my mom take care of my father in the hospital. They didn’t ask me to do it. In fact, my mom was worried that I was going to fall behind a semester. I told her: “the most important thing for me right now is my dad. I will go back to school once he gets better.” Over the next six months my father began a slow process of recovery. Just days before Thanksgiving we were told that we could finally take him home. It was a long haul, but ultimately he recovered. I returned to the university in Spring 2012. My dad always told me: “your education is the only inheritance that I will leave you when I am no longer here.” Those words were inscribed in me and motivated me to finish my degree. My dad has the following advice for future health care providers: learn a variety of languages so that you can help people who don’t understand, let the community know that you are there to help and treat all your patients with love and compassion.

2 The underlined portions refer to scoring units.


Martínez, Glenn. (2016). *Negotiating Border Health: Translanguaging, Entrepreneurship and Capabilities in the Discourse of Promotoras in the Colonias of South Texas*. Presented at the XXII Graduate Colloquium of Iberian and Latin American Languages & Cultures, The University of Texas at Austin.


