In Brief

Shared language between patients and health care providers enables gathering information to arrive at diagnoses, explaining treatment strategies, and ensuring understanding and joint decision-making. This article reviews the history of language diversity in the United States and the effects of language on immigrant integration and health literacy. It offers lessons for health communication and proposes that truly effective health communication with minorities of different languages involves more than merely language concordance.

Language and Health Care

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Effective communication is a marker of health care quality. Shared language between patients and health care providers enables gathering information for diagnosis, explaining treatment strategies, and ensuring understanding and joint decision-making. Yet every day, medical mishaps—some with deadly consequences—occur in health care organizations because of poor communication that occurs on a much broader scope than merely poor transmission of data or information exchange.[1] The risks of communication failure are clear when patients and health professionals do not speak the same language. This article reviews the history of language diversity in the United States and the effects of language on immigrant integration and health literacy. It offers lessons for health communication and proposes that truly effective health communication with minorities of different languages involves more than merely language concordance.

A Nation of Immigrants

Long before the birth of the nation was imagined, early Americans in pursuit of a better life arrived on the eastern shores of what is today the United States. This historical beginning seeded the idea that America is a nation of immigrants, which was advanced by France's gift of the Statue of Liberty, offering refuge to the huddled masses during four massive waves of immigration. The largest wave occurred between 1880 and 1920, when 23 million immigrants from southern and eastern European countries (Italy, Poland, Russia, and Hungary), as well as Mexico and Japan, became permanent residents.[2] During no other period, including today, has the foreign born population made up a larger share of the U.S. population (just less than 15% in 1890).[3]

The fourth and most recent wave of immigration, beginning in 1960, was made long-lasting with the passage of the Immigration Act of 1965, which abolished national origins quotas and dispersed visas more equitably around the world. This policy change, together with undercurrents of global economic integration and demand for unskilled labor, created receptive conditions for immigration from Latin America and the Caribbean. U.S. military involvement in Southeast Asia also helped to promote immigration from Southeast Asia, primarily Vietnam, Cambodia, and Laos.

In 1960, eight of the top 10 source countries of immigrants were European; today, the source countries are in Latin America (largely from Mexico) or Asia.[4,5] (The U.S. Census uses the term "Asian" to refer to peoples of the Far East, Southeast Asia, or the Indian subcontinent, including among others, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. The term "Pacific Islander" is used to refer to peoples of Hawaii, Guam, Samoa, or other Pacific Islands.[6]) Unlike previous waves of immigration, this one also brought significant numbers of illegal

immigrants. Nearly one-third of the ~ 38 million new immigrants entering the country during this period have done so without authorization.

English and National Identity

The ability to speak English is a key component of national identity and is, for some, indicative of a true American.[3,7] In health care, speaking English is central to good communication and is crucial in obtaining quality services and appropriate care. The relationship between ability to speak English and quality of health care received has been established by research linking limited English proficiency with less care-seeking, diminished quality of and access to health services, poorer health outcomes, and even death.[8–12] Accreditation and quality standards adopted by regulatory and oversight agencies now emphasize communication practices, both broadly and across languages specifically.

Religious, political, and racial attributes of immigrants traditionally have been considered barriers to integration, not only for today's immigrants, but also for southern and eastern European immigrants 100 years ago. During that era, Italian culture was thought to "inhibit assimilation."[13]

But contrary to common perception, today's immigrants are integrating and mastering English at faster rates than did immigrants of the past. Less than half of all immigrants who arrived between 1900 and 1920 spoke English within 5 years, compared to more than three-fourths of all immigrants who arrived between 1980 and 2000.[14] This trend continues over a longer timeframe. After 20 years in the United States, more recent Latin American and Asian arrivals learned English faster than immigrants from the first two decades of the 20th century.[14]

English fluency of first-generation immigrants is likely to be uneven, and this group is more likely to require language assistance. Latin America immigrants have the highest rate of limited English proficiency (64.7%), followed by Asians ($6.6%) and Europeans (29.8%).

Some contend that the grandchildren of today's new immigrants will hardly speak the language of their ancestors at all. The U.S. Census categorizes English-speaking ability as "very well," "well," "not well," and "not at all." According to Census data, the proportion who speak only English or who speak English "very well" jumps to > 80% by the second generation for all groups. By the third and higher generations (children U.S.-born parents), nearly 100%, regardless of ethnic or racial group, speak only English or English "very well."[15]

How Language Works

Understanding how language works is important to good communication. Every language is a system of arbitrary signals that grows over time. Language is acquired and learned through social interactions, experiences, and formal and informal education. William C. Fowler, son-in-law of lexicographer Noah Webster, wrote in 1855, "A language . . . grows by grafts from without and by germs from within. As new ideas germinate in a fertile mind, they often come forth in new forms of expression, which sometimes become permanent portions of the language. Foreign terms are imported. New terms are applied to new inventions in art or new discoveries in science. An old term applied to a single object is transitively applied to other objects."[16] In other words, language is constantly changing and evolving to reflect current-day social and cultural realities and times. New words and phrases continuously become part of the everyday lexicon (e.g., "Google," "wiki," "health insurance exchanges," and "Medicare doughnut hole").

Elements of language enable thoughts and feelings to be conveyed through voice sounds, gestures, or writing. Linguists and cognitive scientists say that language influences how people think and view the world; it is a window on how the human mind works. Mental and social constructs are embedded in language to describe thoughts, interpret meaning, and interact with others.[17] In this sense, language and its elements of form, words, grammatical patterns, and usage conventions are units of cognition. Moreover, context and other elements such as the environment, setting, and nonverbal gestures lend meaning to spoken words.

A language of a nation, people, or other distinct community is a shared system of rules for combining its components (e.g., words and gestures). Domain knowledge goes beyond language to specialized knowledge and understanding of the workings of a defined field such as health.

The gap between everyday language and health domain vocabulary is the focus of health literacy and concerns about average individuals' ability to understand and make decisions from health information. For immigrants, differences between languages (English-Spanish) and regional varieties of the same language are added dimensions of cross-cultural communication.

Within-Language Variation: the Case for Spanish

Spanish is the primary national language for 22 countries (not including Aruba, for which Spanish is only one of four official languages). As with all languages, regional variations exist in speech patterns, intonation, use of accents, vocabulary (including unique country-specific vocabulary), and variation in word meaning and cultural contexts. Nonetheless, the language is the same across these countries.

Numerically, the United States is home to the second- or third-largest population of Spanish speakers, depending on whether foreign students and unauthorized immigrants are counted. U.S. Spanish is distinct because of the large numbers of so-called "heritage speakers," children of immigrants who learn Spanish at home but within an English-speaking context of school and community. Sociolinguistic trends occurring in neighborhoods and workplaces raise awareness and familiarity with differences in vocabulary and in how language is used (e.g., expressions and references), eventually merging regional language variations with local patterns of Spanish-speaking communities in the United States. With financial incentives to create region-neutral programming, Spanish-language media are another important influence accelerating understanding by exposing viewers or listeners to regional language varieties.[18]

The pattern of transitioning from Spanish dominance to English dominance is known as "language shift" and has been documented to last no more than three generations.[19] The Pew Hispanic Center found a dramatic increase in English-language ability from one generation to the next. In a study of 14,000 Spanish speakers,[20] fewer than one in four immigrants (23%) reported being able to speak

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English very well. This increases to 88% for their U.S.-born adult children and to 94% for later generations.

Effects of Language on Social and Economic Integration

Learning English is crucial to the integration and economic success of new arrivals and, by extension, beneficial to host communities. How language is learned influences the development of basic skills crucial to academic success: reading, writing, and speaking.

First-generation American-born children of immigrants and very young immigrant children learn the language of their parents as infants. When they enter school, they are taught English and rarely receive the formal language study necessary to achieve native speaking ability in their first language. These heritage speakers learn their first language on their own, leading to wide variation in language comprehension and quality and generally little to no reading or writing abilities. During a crucial language-learning period, these children are exposed to two different language traditions, a condition that typically goes unrecognized or mediated.[18]

Being placed in the position of learning both languages independently often results in poor English mastery, language adaptations, and language mixing. For example, using English and Spanish within the same sentence and blending English and Spanish to create new words are both common. Blended words such as *lonche* derived from the English *lunch*, *dompe* (*dump*), *yonke* (*junk*), and many more have become incorporated into the lexicon of bilingual and bicultural communities in the United States.[18]

Health Literacy

Health care environments have unique cultures and use language in ways unfamiliar to average visitors. Millions of Americans have trouble understanding and acting on health information, even when language is not a barrier. According to the Institute of Medicine (IOM) Committee on Health Literacy, college graduates and professionals such as teachers and engineers are among those unable to comprehend typical health information.

Understanding health information requires more than reading and writing skills. Health literacy includes listening, speaking, and conceptual knowledge that make it possible to understand health interactions, forms, and instructions.[21] The IOM's groundbreaking 2004 report suggested that the skills required to comprehend health information exceed the abilities of average Americans and recommended that attention be given to how patients discern meaning from the information they receive during health encounters.

Language researchers tell us that words have no meaning until meaning is assigned. In other words, as we learn new words, we associate them with concepts that give the words meaning. Comprehension, then, is based on our ability to link experience and knowledge of the world to the words we hear in an applied context. Collections of words, associated concepts, and meanings are culturally determined—acquired formally through education, dictionaries, and thesauruses and informally through lived experiences with family, friends, and coworkers and other socializing events such as movies and news reports. Common experiences lead to common reference points.

Language differences also serve to magnify the specter of other likely differences because of cultural orientation and life experiences associated with the home country and the immigrant experience. The greater the differences, the more likely the frames of reference drawn on will be different. Therein lays the potential for misunderstanding.

Consider the difference between average American doctors or nurses and newly diagnosed patients with diabetes. Although words such as blood, sugar, diet, and exercise are familiar to the patients, the new context of a complex disease may still cause confusion.

Not surprisingly, even with high-quality diabetes education provided in the language patients speak, erroneous beliefs that one can catch diabetes from someone else, that insulin is addictive and can cause blindness, or that people with diabetes cannot eat sweets may persist. If simple explanations fail to make sense to English-speaking college graduates and professionals, imagine what can happen when we consider that a typical health dictionary contains about 40,000–45,000 entries, and English-speaking children often are expected to pass on diabetes education to parents who do not yet speak or understand English.

Moreover, completely unrelated confounders such as reimbursement practices, local and national policies, economic trends, and technology—all of which influence how health care is organized and delivered—can infuse unintended meaning. The nature of local institutions and defined business relationships play a pivotal role in forming the character of local health care delivery systems and practices. Whether intended as such or not, practice culture or referral patterns are often incorrectly understood to be connected to the larger health system requirements users must navigate.

Not surprising, populations with limited English proficiency are more often unintentionally confused. For example, a referring physician may consider a patient noncompliant for failing to keep a referral appointment when, in fact, the specialist's office canceled the appointment because of a pressing emergency. The patient, meanwhile, may have interpreted the cancelation as the specialist's opinion that nothing can be done for the concern that prompted the referral.

Language discordance is but one of many obstacles to good communication with patients. The design and practices of health systems in home countries also may influence immigrants' health care–seeking behaviors. High no-show rates may stem from health systems in home countries that operate on a drop-in or first-come-first-served basis. Understanding health care–seeking behaviors enables providers to adopt practice models (e.g., walk-in clinics) that correspond to community norms or to invest in long-term educational or behavior-modification strategies.

Lessons for Effective Health Communication

Speaking a common language enables, but does not ensure, effective communication. The Joint Commission, the accrediting organization for hospitals and health care facilities, has concluded that the high rate of adverse events related to poor communication is unacceptable. Not surprisingly, health communication failure is more likely for populations with limited English proficiency. Studies have consistently confirmed that the skills required to comprehend and use typical health care information often

exceed the abilities of average patients and must be narrowed, especially for populations with low English proficiency and low health literacy.[22]

Health information must be culturally relevant for patients with low English proficiency. Driven by immigrants' desire to improve their circumstances, the integration process begins early and is rapidly advanced by the second generation (children of immigrants). Although cultural beliefs and values are durable, dislocation and new social contexts trigger culture and language shifts, which occur at different rates and to varying degrees and are highly correlated to age. These transitions are likely to add to, but not to replace, long-held beliefs and traditions.

Health communication strategies need to acknowledge native language use in an English-speaking context and both traditional and contemporary cultural influences associated with immigration. Moreover, language is dynamic, constantly changing to reflect ongoing social and cultural changes. No longer exposed to the home-country environment, immigrants often fail to keep pace with changes in their native language. At the same time, English words and references in their new environments are adopted into the lexicon of immigrant communities. Health communications for immigrant populations, then, need to recognize sociolinguistic and cultural shifts taking place in these communities and to adopt practices to reflect these experiences.

Shared understanding is basic to effective communication. Health communications can be made more effective by acknowledging the high potential for poor communication in general and to an even greater extent with immigrant populations. This article suggests that health communications should be seen as similar to foreign language exchanges that require proactive attention to the use of language. This includes consideration of potential cross-cultural biases associated with concepts and word choices, any required background knowledge, and proactive adoption of standards for frequently encountered referents or terms. Standards can promote routine and consistent use of simplified descriptions and explanations and can include adoption of routine practices such as teach-back techniques to verify patients' understanding or confirm meaning.

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