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Recognizing and Dismantling Raciolinguistic Hierarchies in Latinx Health

Pilar Ortega, MD, Glenn Martínez, PhD, MPH, Marco A. Alemán, MD, Alejandra Zapién-Hidalgo, MD, MPH, and Tiffany M. Shin, MD

Abstract

Latinx individuals represent a linguistically and racially diverse, growing US patient population. Raciolinguistics considers intersections of language and race, prioritizes lived experiences of non-English speakers, and can help clinicians more deftly conceptualize heterogeneity and complexity in Latinx health experiences. This article discusses how raciolinguistic hierarchies (ie, practices of attaching social value to some languages but not others) can undermine the quality of Latinx patients' health experiences. This article also offers language-appropriate clinical and educational strategies for promoting health equity.

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Raciolinguistics

Hispanic/Latinx (hereafter, Latinx) individuals in the United States represent a culturally, racially, and linguistically diverse and rapidly growing population. Attempting to categorize all Latinx individuals in a single homogeneous group may result in inappropriate stereotyping,¹ inaccurate counting,^{2,3} ineffective health interventions that insufficiently target at-risk subgroups,⁴ and suboptimal health communication.⁵ A more helpful approach is to use raciolinguistics to conceptualize the heterogeneous, complex Latinx experience as it relates to health. Raciolinguistics is the study of the historical and contemporary co-naturalization of race and language and their intertwining in the identities of individuals and communities. As an emerging field that grapples with the intersectionality of language and race, raciolinguistics provides a unique perspective on the lived experiences of people who speak non-English languages and people of color.⁶ As such, understanding raciolinguistics is relevant to providing language-concordant care⁷ to patients with limited English proficiency (LEP), who have been historically marginalized by structural barriers, racism, and other forms of discrimination in health care.

In this manuscript, we explore how raciolinguistics can help clinicians to appropriately conceptualize the heterogeneous, complex Latinx experience as it relates to health care. We then use the raciolinguistic perspective to inform strategies to dismantle structural

barriers to health equity for Latinx patients pertaining to (1) Latinx patients' health care experiences and (2) medical education.

Raciolinguistic Latinx Experiences

Sociological understandings of “race” presume that race is a social construction in which biological and other features serve as indices of societal values and generate enduring racial logics (ie, the use of race to define an individual or community's social structure or status).^{8,9} While not a race in the phenotypic sense, Latinx people have been racialized in the United States following a pattern similar to that of other minoritized groups.^{10,11} Like race, “ethnicity” is a socially constructed category; depending on the context, the term *ethnicity* may refer to an individual's culture, heritage, ancestry, or national origin.¹² Although governmental classifications, such as in the US census, refer to “Hispanic or Latino” as an ethnicity,¹³ persons who identify (or are labeled) as Latinx may be of multiple races, nationalities, ethnicities, or cultural or linguistic backgrounds.

Language is a salient feature of the racial formation of Latinx and other groups. Early research on linguistic profiling demonstrated that racial discrimination is often predicated on the sound of one's voice and the images that those sounds conjure in the imagination of an interlocutor.¹⁴ This research suggested that particular linguistic forms are linked to particular racialized phenotypic characteristics, which, in turn, index societal values and perceptions. Recent research on the relationship between language and race, however, moves beyond this early theorizing and argues not that language indexes race but rather that language and race have become co-naturalized.⁷ In this way, saying that someone “sounds Mexican” is not an objective appraisal of speech but rather a subjective “racing” of that person. In other words, to say that someone “sounds Mexican” is to place that person in the category *Mexican* and, at the same time, to foreground the societal values and perceptions of “Mexican” people.

A raciolinguistic perspective opens new understandings of the social meanings attached to languages and varieties of language in the United States and beyond.⁶ It has long been established that no single language or variety of a language is superior to or more complex than any other but, instead, that all languages and varieties serve their users equally well to express themselves, and all constitute rule-governed systems.^{15,16} Even so, not all languages and varieties enjoy the same social prestige.¹⁷ The values attached to speakers of a language often overlap with the very same values attached to them as part of a racialized group,¹⁸ resulting in intersecting social perceptions of race and language “experienced in powerfully embodied and perceivable ways.”¹⁹

Central to the formation and maintenance of raciolinguistic hierarchies is the concept of the listening subject.⁷ Raciolinguistic hierarchies are maintained not so much because speakers choose to speak in one way or another but rather because listeners choose to listen in particular ways. Let us consider again our initial example: “you sound Mexican.” While this may ostensibly be an observation about how someone else speaks, it is actually more revealing of the way the person who says it *hears*. “You sound Mexican” is always equal to “you sound Mexican to me.” Understanding raciolinguistic hierarchies in health care allows for recognition and a deeper understanding of structural barriers to Latinx health equity.

Improving Latinx Health Experiences

Raciolinguistic hierarchies have been documented in the health care experiences of US Latinx and limited English proficiency (LEP) populations.^{20,21,22,23} For example, a study of 20 Latinx immigrant women in 2 community health centers in Utah found that patients reported often being the target of discrimination because of the way they looked or spoke.²² One participant commented: “I was often made to wait for hours, just sitting there, while other white people were tended to first.”²² Another study of the health care experiences of Latinx mothers in Detroit and Baltimore found that the perception of discrimination was heightened by the “battle” to manage language barriers.²³ The cumulative exposure to **discrimination across generations** may result in long-lasting negative health consequences for the US-born children of Latinx immigrants.²⁴

Conversely, increasing the number of linguistically and culturally concordant physicians might attenuate perceptions of discrimination and “othering” in health care. Patients with LEP and type 2 diabetes are less likely to perceive discrimination when treated by a language-concordant clinician.²⁵ Similarly, Latinx patients treated by a Latinx mental health professional reported improved communication and a stronger working alliance.²⁶ Strategies to dismantle raciolinguistic hierarchies in health care also should include thoughtful attention to posting multilingual signage, hiring patient navigators, providing multilingual patient information, ensuring language-appropriate access to scheduling and digital health platforms (eg, telemedicine), engaging with Latinx populations through community health worker programs, and partnering with professional medical interpreters (see Table). Signage and written material should reflect the language of the target population rather than **jargon** that may not be easily understood.

Table. Manifestations of Raciolinguistic Concepts in Health Care and Proposed Solutions to Improve the Latinx Health Care Experience and Medical Education

Raciolinguistic Concept	Manifestation of Raciolinguistic Concept in Health Care	Example of Problem	Proposed Solution
Racial logics	Interaction and intersectionality of race, language, ethnicity, and national origin	<p>Patients who are non-English speakers are perceived to be health illiterate.</p> <p>An individual who self-identifies as Latinx is assumed to be “White” based on their physical appearance upon hospital registration.</p>	<p>Critically review educational cases to ensure thoughtful representation of Latinx patients of varied nationalities, races, and educational level.</p> <p>Engage with Latinx community organizations to better understand community language and health literacy needs and/or create joint programs (eg, with patient navigators, community health workers).</p> <p>Ensure electronic health record systems have user-friendly fields to facilitate accurate language documentation.²⁷</p>
Raciolinguistic hierarchies	Microaggressions	<p>A medical student with a “Spanish-sounding” name is asked to interpret during a medical encounter with a Spanish-speaking patient.</p> <p>Signage or forms are translated into Spanish but include medical jargon and language structures that are not well understood by the target population.</p>	<p>Establish clear health system policies regarding professional interpreter use.²⁸</p> <p>Make professional interpreters accessible and train staff to work with them.²⁸</p> <p>Review written materials and educational resources in non-English languages for readability level and engage community members and organizations for feedback on comprehension.</p>

Listening subjects	Implicit bias	A patient is assumed to have certain cultural health beliefs based on their ancestry, race, or language and is not offered a specific health service (eg, oral contraceptives, vaccination, colonoscopy) because it is assumed the patient will refuse.	Train staff to consistently and respectfully ask patients about language preference (eg, “What language do you prefer we use for today’s visit?” or “In what language would you be most comfortable for this visit?”) ²
		Some varieties of Spanish are judged to be better or more valid than others.	Develop clinical cases that reflect authentic Latinx experiences and varied cultural beliefs and practices rather than stereotypes. Involve Spanish speakers who reflect multiple varieties of Spanish in courses as teaching assistants, guest speakers, or pre-recorded audios or videos.

Latinx patients may preferentially speak a variety of languages. Recent data show that 38% of US Latinx individuals mainly speak Spanish and 36% use both Spanish and English (at variable skill levels), whereas 25% mainly use English.²⁹ Yet Spanish speakers compose 64% of US individuals with LEP,³⁰ and one-third of US Latinx individuals ages 5 and older report difficulty communicating in English.³¹ Other language preferences of US Latinx subgroups that are not as well studied include Portuguese, Indigenous languages (eg, Mayan, Quechua), or a combination of languages (eg, Spanglish). Despite diverse language needs, Latinx individuals may feel pressured to select “English-speaking” on medical forms due to discrimination fears, or they may be labeled as English-speaking if they are accompanied by an English-speaking family member. Such incorrect labeling may result in underrecognizing the need for onsite professional medical interpreters—an evidence-based intervention that significantly improves communication, patient outcomes, patient satisfaction, and health care utilization.³² To dismantle raciolinguistic hierarchies in Latinx patient care, health care centers must ensure that staff are trained in clear policies and procedures regarding accurate, consistent, and respectful collection of demographic information, including language preference,^{2,27} and that patients and staff can easily access professional language services²⁸ (see Table).

Improving Education by Applying Raciolinguistics

Strategies to teach patient-centered communication skills with ethnic, racial, and linguistically diverse groups, such as unconscious bias training and medical Spanish courses, are in increased demand in medical education.^{33,34} However, curricular materials may unintentionally reinforce raciolinguistic hierarchies, stereotypes, and implicit bias by predisposing learners to view Spanish speakers through the lens of myriad social problems, such as alcoholism, teen pregnancy, poverty, health illiteracy, and incarceration.³⁵ For example, while it would be useful for some medical Spanish role plays to illustrate Latinx patients with low health literacy, it would be more valuable to teach how clinicians should respectfully evaluate the educational level of Spanish speakers and adjust their communication register accordingly. Similarly, while some Latinx patients may express cultural reasons for refusing a medical recommendation, it would be inappropriate and inaccurate for all or most simulated encounters to reflect Spanish-speaking patients refusing care; this stereotype could perpetuate incorrect attribution of a cultural belief and deter clinicians from offering indicated services that they believe will be refused. Some data show that non-English speakers are less likely to receive a recommendation from their physician for potentially lifesaving health services, such as colorectal cancer screening.³⁶ Medical education should broaden and enrich learners’ understanding of the heterogenous, diverse Spanish-speaking population

rather than restrict language skills application to basic patterns that are often inaccurate.

Additionally, clinical communication skills training focusing on the needs of minoritized groups, such as non-English speakers, is often limited to students who specifically seek **electives related to improving language** or cultural skills (eg, medical Spanish courses or study abroad clerkships).³⁷ However, given trends in US demographic data, all clinicians, regardless of their preexisting language or cultural skills, should be equipped to care for linguistically diverse populations.³⁸

Among potential strategies for remedying racial inequities, Fair and Johnson recommend rigorously analyzing the use of race in clinical tools and practices, medical education, and research and centering communities' voices in health interventions.³⁹ Naming racism³⁹ and "intersecting forms of oppression,"⁴⁰ such as discrimination against patients who prefer non-English languages, is critical to making the needed educational and health care systems changes to ensure quality care for Latinx individuals. Analyzing medical education through a Latinx lens requires addressing the intersectionality of race and language and ensuring that it is appropriately reflected in educational materials (see Table). For example, schools should review their curricula, particularly in clinical skills, patient cases, and content about social determinants of health or health inequities to identify where and how the Latinx community is represented.

Next, educators should examine how teaching materials portray Latinx patients and make adjustments as needed. For example, materials should not portray immigrants negatively and all non-English speakers as having low health literacy. Educators should consider modifying materials and rosters of standardized patients to reflect raciolinguistic diversity. For instance, in the cardiac block, a clinical scenario could be added in which a student's task is to interview a patient with LEP who presents with chest pain. Diverse actors, when empowered, can provide a valuable community perspective that ensures that language varieties, cultural beliefs and practices, and other elements of a case are authentic rather than stereotyped.⁴¹ Following such simulated encounters, guided reflection regarding their attitudes, performance, and feelings can help students better understand the complex relationship between race, ethnicity, and language as well as how their assumptions or lived experiences inform their medical interactions or decision making.

Medical school curricula should account for the skills and needs of diverse learners—for example, Latinx students with Spanish language skills or cultural knowledge or experiences.⁴² Institutional policies should address bilingual students' and clinicians' appropriate use of language skills, including clearly outlining qualifications and appropriate assessment methods and distinguishing the skills and roles of learners from those of medical interpreters.³⁷ These policies should protect untrained bilingual or bicultural students and staff from inappropriate requests to serve as **ad hoc interpreters**, a common workplace microaggression, thereby improving patient safety and quality of care for patients who speak non-English languages.

Conclusions

A raciolinguistic perspective can inform how health care practices and medical education should be critically examined to support Latinx populations comprising heterogeneous communities and complex individuals with varying and intersecting cultural, social, linguistic, racial, ancestral, spiritual, and other characteristics. Future

studies should explore the outcomes of raciolinguistic reforms of health services and educational interventions across the health professions to ensure effectiveness in improving health care for Latinx patients.

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Pilar Ortega, MD is a clinical assistant professor in the Departments of Medical Education and Emergency Medicine at the University of Illinois College of Medicine in Chicago. As an educator and researcher, she focuses on medical Spanish education and assessment, as well as on patient-centered communication in non-English languages. She is also the founder of 2 nonprofit organizations that aim to improve minority health and reduce health disparities: the Medical Organization for Latino Advancement and the National Association of Medical Spanish.

Glenn Martínez, PhD, MPH is a professor of Spanish and the dean of the College of Liberal and Fine Arts at the University of Texas at San Antonio. His research focuses on sociolinguistics and applied linguistics of Spanish-speaking communities in the United States and along the United States-Mexico border.

Marco A. Alemán, MD is a professor in the Department of Medicine and the director of the Comprehensive Advanced Medical Program of Spanish at the University of North Carolina School of Medicine in Chapel Hill.

Alejandra Zapién-Hidalgo, MD, MPH is an assistant professor of family and community medicine and the director of the Bilingual Medical Spanish and Distinction Track at the University of Arizona College of Medicine-Tucson, where she also supports programs offered by the Office of Equity, Diversity and Inclusion that are geared towards increasing the numbers of underrepresented students in health careers.

Tiffany M. Shin, MD is an assistant professor of pediatrics and the director of the Medical Applied Education in Spanish Through Training, Research, and Overlearning Program at Wake Forest School of Medicine in Winston-Salem, North Carolina.

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