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Spanish in the U.S. Health Delivery System

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Topic: Recent research on Spanish in the health delivery system

Summary: This report summarizes current research on Spanish in the U.S. health delivery system, identifies areas of needed future research, and offers recommendations to expand the availability of research in this area.

Keywords: health, Spanish language, health disparities, language access

Introduction

Carlos Alonso recently argued that the social and cultural circumstances surrounding the past, present and future of the Spanish language in the United States incontestably position it as the "Foreign National Language" (Alonzo 2007). Alonso's bold and provocative proposal that "Spanish should no longer be regarded as a foreign language in this country" (p. 222), however, has implications that far surpass the cogent recommendations that he makes

regarding the place of Spanish in academia. The reality to which Alonso refers has cultural, political and economic tentacles that reach deep into multiple facets of social life in the United States. Education, media, marketing and political campaigning are all areas in which the growing importance of Spanish has been felt sharply over the past several decades. Health care delivery is another area in which the ubiquitous presence of Spanish has lingered for many years.

Spanish language professionals in the United States have engaged productively with the presence of Spanish in the health delivery system in various ways. One of the first interventions was the development of specialized curriculum for the teaching of "Medical Spanish" and, to a lesser extent, medical interpreting. Additionally, Spanish language professionals have developed research programs surrounding these activities. In this report, I will argue that the full potential of Spanish language professionals within the health care delivery system has not yet been reached. Specifically, I argue for the need to build support for an expansive research agenda that resides at the intersection of Hispanic linguistic and cultural studies and health services delivery. I will conclude by offering recommendations of specific action items that if taken today will ensure a vibrant and growing research trajectory for Spanish in the health delivery system into the future.

I will begin by describing the increasingly high profile of Spanish in the current health delivery system. I will then review the current trends in research on Spanish in the health delivery system. Following this overview, I will discuss some areas of unrealized research potential of Spanish in the health care delivery system. Finally, I propose a series of recommendations that may contribute to an adequate infrastructure for the forward development of an expansive research agenda for Spanish in the health delivery system.

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The Place of Spanish in the Health Delivery System

The sheer presence of Spanish speakers within the U.S. population suggests that interactions with Spanish speaking patients within the health delivery system are likely to continue or increase in the foreseeable future. The U.S. Latino population in 2013 was about 54 million comprising 17.1% of the entire population (Stepler and Brown 2015). Within this population 7% indicated speaking no English whatsoever, 26% indicated speaking English less than "very well", and a full 74% indicated speaking Spanish or another language in the home (Krogstad, Stepler and Lopez 2015).

The growing Latino patient population within the U.S. health delivery system is intensified by health status disparities and health care inequities that disproportionately affect Spanish speakers. Health status disparities refer to differences in incidence, prevalence, mortality and burden of disease in particular population groups. Health care inequities, on the other hand, refer to disparities in health care access, quality and outcomes (Isaac 2013). Health and health care disparities appear to impact Latinos along what I have called elsewhere a "linguistic gradient" (Martínez 2010). What I mean by this is that health outcomes and health care access and quality for Latinos are stratified along the bilingual continuum. As might be expected, English monolinguals demonstrate better outcome and care indicators than Spanish monolinguals. Epidemiological studies that include language as a variable, however, also show that outcome and care indicators for Spanish/English bilinguals are not as good as they are for English monolinguals and not as bad as they are for Spanish monolinguals. This generalization is borne out in a number of epidemiological studies. For example, a study of self-reported overall health (SROH) and self-reported emotional health (SREH) among English monolingual, bilingual and Spanish monolingual Latinos in California found that the lowest self-assessments of overall and emotional health were attributed to Spanish monolinguals. It also showed, however, that bilingual Latinos rated their overall and emotional health as worse than English

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monolingual Latinos (Ponce 2006). Inasmuch as SROH is an indicator of health outcomes, these data suggest that disparities in health outcomes among Latinos follow a linguistic gradient. Another study of preventive care utilization among a representative sample of women across the nation found that Latina women with fluency only in English were the most likely to undergo cervical and breast cancer screenings and Latina women with no fluency in English were the least likely. However, the results again demonstrated that Latina women with some fluency in English were less likely than English monolinguals but more likely than Spanish monolinguals to undergo cancer screening (Jacobs 2005). These findings were corroborated in a separate study of the association of preventive care utilization and the language spoken in the home. This study found that the likelihood of utilizing preventive care services is diminished in association with the extent of Spanish used in the home. The author's of the study concluded that "English language usage is a marker of health seeking behavior. Persons with greater English language usage are likely to be more acclimated to the dominant culture in the United States and thus may adopt health seeking behaviors of the mainstream population" (Cheng 2007, p. 287).

A third factor that gives Spanish an increasingly high profile in the current health delivery system is the accelerated increase in coverage of Spanish-speaking Latinos under the Affordable Care Act. In 2014, 2.6 million Latinos came under health insurance coverage through the Affordable Care Act. The most pronounced drops in uninsurance rates among Latinos occurred precisely among the Spanish dominant and among the youngest adults as seen in the following graph (Doty 2014):

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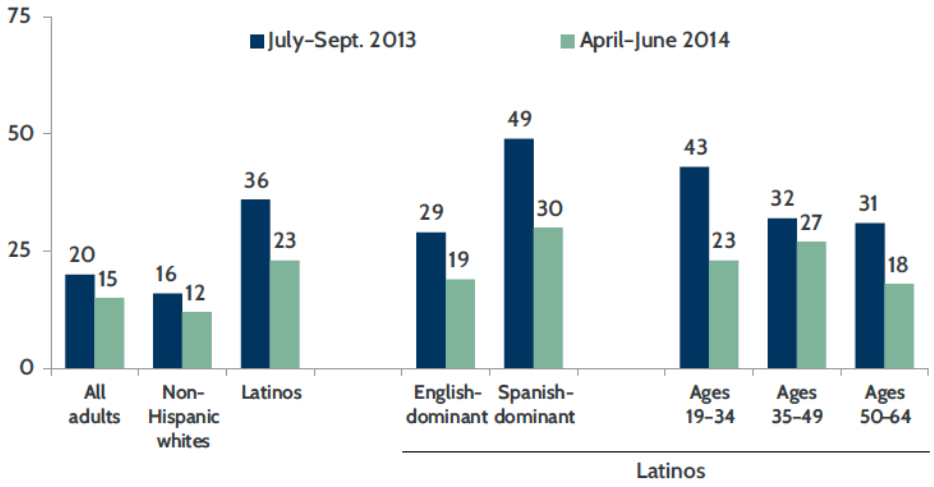

Image 1: The Uninsured Rate among Latinos fell sharply between July-September 2013 and April-June 2014, following the first open enrollment period. The chart shows the percent of adults ages 19-64 uninsured. Source: *The Commonwealth Fund Affordable Care Tracking Surveys*. July-Sept. 2013 and April-June 2014.

While significant challenges remain in bringing all Latinos under coverage including the piecemeal expansion of Medicaid and the presence of many families of mixed immigration status. Notwithstanding these challenges, a full 1/3 of the ACA media budget is dedicated to Latino and Spanish language media (Carey 2015). The impact of the ACA on the health delivery system will be considerable. The data available suggest that the presence of Spanish speakers in the system is likely to increase substantially and that the types of services are likely to shift as well. Given the linguistic and age profiles of those coming under coverage, we would expect to see an increase of Spanish-speaking patients in preventive and chronic care encounters and relatively stable acute care encounters.

The preceding discussion identified a convergence of demographic, epidemiologic, and economic factors that will further raise the profile of Spanish within the health delivery system. The influx of Spanish speakers will certainly present a challenge to the system in it present sociolinguistic make up. It also presents an opportunity for Spanish language professionals to develop a more

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pronounced footprint within health services research. In what follows, I will briefly survey some of the most salient current research on Spanish in the health delivery system.

Current Research on Spanish in the Health Delivery System

Research on Spanish in the health delivery system over the past decade or so has focused on three major lines of inquiry: language concordance, medical interpreting, and the teaching of Spanish to health professionals. Language concordance (LC) research is a type of comparative effectiveness research that compares clinical outcomes of encounters where providers and patients share a language and encounters where they do not share a language. Medical interpreting (MI) research has focused on the utilization of interpreters, shifting roles of interpreters, and accuracy and errors in interpreting. Research on the teaching of Spanish for health professionals (SHP), finally, has focused on the description of linguistic proficiency within clinical domains and measurement of linguistic proficiency through language teaching interventions.

LC research has focused on both provider and patient level outcomes. On the provider level, researchers have studied market-determined earning, medical malpractice concerns, and the likelihood of providing lifestyle counseling within the clinical encounter. Researchers have found that LC physicians have higher per hour earnings in areas with large shares of Spanish-speaking patients (Brown 2007). They've also found that LC physicians were less likely to have medical malpractice concerns when treating limited English proficient patients. The lower intensity of concern, furthermore, corresponded with greater likelihood of providing a clinical diagnosis, less reliance on diagnostic tests and procedures, and a lower rate of specialist referrals (Chen 2011). Finally, researchers have discovered that, at the provider level, LC physicians were more likely than non-LC

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physicians to provide lifestyle counseling on nutrition and exercise when treating Spanish-speaking patients (Eamranond 2009). At the patient level, LC research has pointed to similar patterns. Non-English speaking patients with LC physicians, according to one study, were 3 times less likely to perceive discrimination than non-English speaking patients without an LC physician. This same study revealed that patients with an LC physician were 2 times less likely than patients without an LC physician to indicate a lack of confidence and trust in their physician (Schenker 2010). Other studies have shown that Spanish-speaking patients with LC providers are slightly more likely to adhere to cardiovascular disease medications than Spanish speaking patients with a non-LC provider (Traylor 2010). Finally, a study of Spanish speaking patients with diabetes found that patients without an LC provider were 2 times more likely to have poor glycemic control as demonstrated by an HbA1c reading greater than 9% (Fernandez 2011).

MI research has focused on a series of important research questions. These include questions related to interpreter utilization that have found a persistent use of ad hoc interpreters, family members and friends in multilingual clinical encounters. Ramirez (2008) found that the use of ad hoc interpreters in emergency department visits greatly surpassed the utilization of professional interpreters. An investigation of the reason for this uneven pattern of utilization revealed that providers were hesitant to call for an interpreter because of the increased amount of time it took as well as the increased monetary cost of providing care. Ginde (2009) corroborated this finding in a study of interpreter utilization in Massachusetts after the enactment of legislation mandating the use of professional interpreters. Based on interviews with 530 patients who had received services in the emergency department, the authors found that professional interpreters were only used in 15% of the multilingual encounters where an interpreter was needed. Rose (2010) further elucidates these findings through interviews with 348 physicians. This study showed that only one third of the physicians surveyed indicated good availability of trained medical interpreters. More recent studies have found that faulty patient tracking systems

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may complicate the low utilization of professional interpreters and their limited availability. Okrainec (2014) studied the association between language preference, language proficiency and ability to communicate among 1,000 patients in Montreal, Canada. This study found that 40% of patients indicating low language proficiency and limited ability to communicate were not identified to have a preference for their mother tongue. Similarly, 76% of patients indicating high language proficiency and good ability to communicate were identified as having a preference for the mother tongue. This study suggests that the lack of precision in the determination of language preference may account for the inefficiency of interpreter services.

Research on the role of the medical interpreter has been one of the most fruitful lines of inquiry in applied linguistic research on Spanish in the health delivery system. Beltran-Avery (2001) describes the shifting roles that medical interpreters must assume in the course of an interpreted clinical encounter. While professional standards have strived to define the primordial role of the medical interpreter as a neutral conduit that faithfully renders all of the information from one language to the other, the felt communicative needs in the clinical encounter often necessitate a divergence from the conduit role. Communication management may be required if there is an obvious disconnect between the patient and the provider. Cultural clarification, furthermore, may be needed in order to faithfully transfer the message from one language to another.

Finally, there are times when the interpreter must advocate on behalf of the patient in order to achieve the ultimate goal of patient well being. These deviations clearly place the ideal of interpreter invisibility in jeopardy and raise serious questions about the interpreter's ability to ever achieve neutrality (Angelelli 2004). These questions have been central to the investigation of the roles of medical interpreters. One strand of research in this area is the description of non-conduit roles assumed by interpreters. White and Laws (2009) conducted a qualitative analysis of 13 pediatric outpatient interpreter-mediated

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encounters. The study revealed that role exchanges were most frequent among untrained interpreters and that the exchanges consisted of assuming the provider's role, assuming the patient's role, and taking on other non-interpretive roles such as socializing with patients.

Another strand of research has investigated the conditions that motivate role exchange among interpreters. A study of 26 trained medical interpreters was conducted in the US Midwest to determine the source of role conflict in interpreter-mediated interactions (Hsieh 2006). In-depth interviews with interpreters revealed 3 sources of role conflict: communicative practices of doctors and patients, changes in participant dynamics and institutional constraints. Communicative practices can be a source of role conflict when doctors or patients address the interpreter directly with the expectation that what is said will not be conveyed to the other interlocutor. Changes in the participant dynamics occur when an additional participant, such as a nurse or a family member, enters the communicative event. The presence of an additional participant makes it difficult for the interpreter to determine whether or not the information is meant to be conveyed by the interlocutor. Institutional constraints that can engender role conflict derive from policies that may require an interpreter to step outside of the conduit role. For example, many institutions treat providers' time as a scarce resource and thus require medical interpreters to conduct part of the medical interview.

Bolden (2000) adds to these studies by showing that role conflict may also be produced by assumptions and orientations held by medical interpreters themselves. She concludes that interpreters routinely relinquish passive participation in the interaction and assume gate-keeping functions that pursue "diagnostically relevant" information and suppress subjective accounts of patients' psychosocial concerns. The complicity of medical interpreters in institutional gate keeping has been shown to be institutionally driven (Davidson 2000) and to construct non-English speaking patients as passive and non-

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compliant (Davidson 2001). In sum research on the roles of the medical interpreter have highlighted the complexity of interpreter-mediated clinical interactions and the power that institutions exert in constructing non-English-speaking patients as docile bodies.

MI researchers have also focused on accuracy and error-analysis in interpreter-mediated interactions. Through fine-grained analysis of interactions, this strand of research seeks to classify the types of errors made in the course of interpreting and to determine the errors characteristic of different types of interpreters. Flores (2003) studied 13 interpreter-mediated interactions to determine the types of errors and to assess their potential clinical consequences. The study identified five main error types: omission of information, false fluency (grammatical and lexical errors in Spanish), substitution, editorialization, and addition. The errors were deemed to be of clinical importance when the message in which the error occurred could result in adverse effects on health. Examples of such errors included omissions of questions about drug allergies, addition of information about medication administration, and editorial comments that contradicted clinician recommendations.

The analysis of interpreting errors and their clinical consequences has been successfully used to assess the effectiveness of ad hoc interpreters. Elderkin-Thompson (2001), for example, analyzed 21 interpreter-mediated clinical encounters where bilingual nurses performed the duties of the interpreter. In one half of the encounters analyzed, the researchers found serious errors that affected the physician's understanding of the symptoms or the credibility of patient concerns. The preponderance of these errors suggested fundamental differences between the linguistic mediation enacted by trained interpreters and by untrained bilingual nurse-interpreters.

SHP research has focused on three broad areas including the description of Spanish language proficiency in clinical domains, the impact of low levels of

proficiency in clinical encounters, and the measurement of second language acquisition in medical Spanish programs.

The description of language proficiency in clinical domains has become an important issue in applied linguistic research on Spanish in the health professions. The specific L2 skills needed to provide linguistically appropriate services has been a focal point of this research. A study of successful oral interaction between nurses and language minority patients found that speech tasks dealing with emotional aspects of caregiving were the most demanding in terms of L2 ability (Isaacs 2011). This research suggests the need for the establishment of specific functional targets in the teaching of an L2 for medical purposes. Diamond (2009) points out the difficulties in adequately describing Spanish language proficiencies in health care domains and argues that much of the ambiguity is a result of pedagogical approaches to teaching Spanish for health care professionals. She notes that a distinction must be made between general linguistic proficiency and domain-based linguistic proficiency. Medical Spanish is generally concerned with developing lexical competence to adequately describe illness, injury, diagnosis, and treatment in the clinical setting. Even so, it does not reflect the additional linguistic and pragmatic competencies needed to adequately engage in conversation with Spanish speakers about these issues. She concludes her discussion stating that "use of ambiguous terms, such as 'medical Spanish,' offer little information about linguistic skills… moving to a consistent way of describing linguistic proficiency could ensure higher-quality health communication for patients with limited English proficiency" (p. 428).

The issue of accurately describing language proficiency among health care providers grows in importance when taking into account the clinical consequences of treating patients with inadequate levels of linguistic competence. Numerous scholars have likened the use of imperfect L2 skills to using ad hoc interpreters. Studies of language proficiency over-estimation have attempted to determine at which levels of proficiency physicians are most likely to

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rely on their own language skills rather than solicit the assistance of a professional interpreter.

Diamond (2012) conducted a survey of 68 physicians on the general medicine floor of a large urban hospital in northern California. Physicians were classified according to Spanish proficiency self-ratings using a five-point scale. They were then asked to describe the specific strategies they used to overcome the language barrier. The strategies described were: using their own Spanish skills, using professional interpreters, and using ad hoc interpreters. The researchers found that physicians with low-level Spanish proficiency reported frequent use of ad hoc interpreters for information-based scenarios but used professional interpreters for difficult conversations and procedural consent. These physicians also reported using their own skills to greet patients or make small talk. Physicians with medium proficiency relied more on their own language skills but still used professional interpreters for difficult conversations. Physicians with high-level Spanish proficiency relied almost exclusively on their own language skills. This study revealed that all physicians used their Spanish language skills on the job regardless of their proficiency in the language. Those who self-rated at a medium level of proficiency, however, were most likely to forego the use of an interpreter in obtaining information from patients. This research suggests the need for physicians to be trained in reliably assessing their language competence and in discerning when to use medical interpreters.

The measurement of language acquisition in Spanish for health professional courses and programs has also become an increasingly important area of inquiry. Reuland (2008) conducted a longitudinal study of a medical Spanish course offered in a medical school setting. The curriculum included didactic lectures, practice with simulated patients, and socio-cultural seminars. The program assessment focused on development in two separate proficiency measures: a speaking proficiency score and a listening comprehension score. The study found that while speaking proficiency remained unchanged from baseline, listening

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comprehension increased dramatically. The passing rate on the listening comprehension test increased from 72% at baseline to 92% at evaluation point.

Other programs have demonstrated more robust results. An assessment of a course in Spanish for nurses at the University of Texas at Austin, for example, found that through role-play and simulated patient care scenarios, students were able to develop not only improved speaking abilities but also improved command of communication strategies in Spanish. For example, students developed skills in asking clarification questions, using repetition for clarification, and reading body language (Bloom 2006). Other strategies have also been found to be effective in developing these productive language and interpersonal communication skills. Reuland (2012) conducted a study of the impact of an international rotation on medical students learning Spanish for the health professions. International rotations are immersion experiences where students have the opportunity to engage in clinical practice in a Spanish-speaking country. The international rotation had an appreciable effect on speaking abilities. The likelihood of having greater speaking ability was 80% among those who participated in a clinical rotation in a Spanish-speaking country, but it was only 46% for those who had not participated. This study demonstrated the need for a multi-faceted approach to the development of medical Spanish that includes both formal instruction and immersion experiences in a clinical setting.

New Directions in Research on Spanish in the Health Delivery System

Research to date on Spanish in the health delivery system has created a solid foundation for future development. In what follows, I will describe some of the most immediate research questions that arise from both the existing research and from current trends within health services and clinical research. I will

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organize my comments in three broad categories that address questions in descriptive research, intervention research, and patient-centered research.

Within descriptive research, we have gained a great deal of understanding about the impact of limited English proficiency and bilingualism on health outcomes and access to health care. We do not yet fully understand, however, the mechanisms and strategies that minority language communities use to obtain, comprehend, and negotiate health information. The literature on the efficacy of *promotora* and patient navigator interventions is plentiful (Balcázar 2009, Castillo 2010, Deitrick 2010). There is also a growing body of literature that points to the role of collectivist and *familismo* cultural values in the negotiation of health information in Latino communities (Blewett 2003, Garza 2010, Villalobos 2015). However, granular analysis of the discourse strategies and cultural practices utilized by family members and community health workers to promote greater access to care and behavior change has not yet been conducted. These analyses could help us to uncover the unique multilingual literacy practices that emerge in the reception of health information, the role oral cultures play in health information transmission, and the negotiation of multiple and conflicting circuits of knowledge in health care decision-making processes. In order to gain ground in these areas, we will need to draw on ethnographic research techniques that are rooted in sociocultural linguistic and cultural studies traditions. We will need to analyze and interpret the lived experiences of minority language patients through the lenses of sociolinguistic, cultural and social theories. And finally, we will need to compare collective behaviors of health with other known cultural practices and behaviors in order to shed additional light on their underlying logic.

In the area of intervention research, on the other hand, there is a need to go beyond our current understanding of language concordance. The health protective benefits of language concordant health care encounters have been well attested in the literature, but we have not yet developed interventions that would lead to an expansion of these health protective benefits to larger segments

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of the population. In order to advance this line of research, we would need to ask what types of interventions would promote the known benefits of LC interactions including increased trust, better communication, and enhanced health outcomes.

The Integrated Second Language Learning for Chronic Care project at The Ohio State University is one example of this type of intervention research. This project proposes to test the efficacy and acceptability of an educational intervention designed to develop skills for nurse practitioner students to engage in productive primary care interactions with Spanish speaking patients with diabetes. The nurse training intervention integrates second language instruction, health communication training, and clinical instruction in order to develop the skills needed to engage in chronic care counseling encounters. The intervention spreads the instructional content over a series of educational delivery methods including classroom instruction, supervised clinical instruction, and cultural immersion. The evaluation of the intervention examines and correlates linguistic and communicative gains observed in students with patient level variables known to be influenced by LC encounters such as trust, perceptions of discrimination, medication adherence, and glycemic control. The outcomes of the study will shed light on the feasibility of spreading the benefits of LC interactions within the front lines of the primary care health care workforce.

Research on Spanish in the health delivery system has not yet engaged with patient-centered methodologies. Patient-Centered Outcomes Research (PCOR) is focused on answering questions that matter to patients in pragmatic, clinically-relevant, ways with consistent engagement with patients and other stakeholders including clinicians, payers, policy makers and others. PCOR approaches have the potential to significantly advance our understanding of language access in health care. Through engagement of patients and other language access stakeholders including clinicians (both bilingual and monolingual), medical interpreters, medical interpreter agencies, *promotoras*, and payers, PCOR can bring to light the questions that matter most to patients with respect to language access and

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develop ways of addressing these questions in clinically expedient ways. These approaches promise to take us beyond the current questions in MI research and begin to nurture a more comprehensive understanding of patient perspectives on linguistically mediated health care interactions.

PCOR approaches to language access, furthermore, may become recursive to the extent that we desire to incorporate Spanish-speaking patients in the larger field of pragmatic clinical and comparative effectiveness research. More specifically, PCOR approaches to language access can inform and establish the communicative interactions that best provide access and promote participation and integration of Spanish-speaking patients on research teams. In sum, then, PCOR truly constitutes the next frontier of research on Spanish in the health delivery system.

Recommendations

The forward trajectory of Spanish in the health delivery system research is ripe with potential. As Spanish language professionals, however, it is incumbent upon us to ensure that this potential is adequately realized. In the final section of this report, I will offer some recommendations on some of the more immediate actions that the profession can take to ensure an adequate infrastructure to support and nurture linguistic and cultural research on Spanish in the health delivery system.

First, I perceive a need to inject health related topics into the graduate level curriculum in departments that offer advanced degrees in Spanish. In institutions with integrated health science centers, this infusion might include drawing on instructional resources in health related colleges such as nursing, public health and medicine. Introductory graduate level courses in public health, epidemiology, community health, health promotion, and health policy would give future Spanish

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language researchers a foundation upon which to roll out a research trajectory involving Spanish in the health delivery system. In institutions without integrated health science centers, efforts can be made to strategically leverage the growing demand for courses in Spanish for the health professions at the undergraduate level. Scholars hired to teach these courses at the undergraduate level, for example, could be encouraged to develop graduate level seminars to foster research at the intersection of Spanish linguistic and cultural studies and health services research.

Second, we should seek out opportunities to extend Spanish language expertise to graduate and professional students in health science programs. Masters level programs in Spanish, for example, can be combined with professional degrees such as the MD, the MSN or the MPH in order to provide health service researchers the language skills and the appropriate sociolinguistic and cultural perspectives to carry out health research in Spanish speaking communities. Such complementary degree programs would be extremely attractive to the extent that the curriculum is flexible enough to allow students to leverage community-based and international rotations, clinical, and practical as part of both degrees. The academic core of the degree, however, would be similar to existing MA level programs with distribution requirements in literary, cultural and linguistic studies.

Finally, we should build on the growing interest in Spanish by undergraduate students in pre-health programs. Existing intermediate and advanced language courses in Spanish for the health professions may be complemented with other advanced courses in linguistics, literature and cultural studies focused on health related issues and topics for Spanish majors, Spanish minors, and undergraduate students enrolled in interdisciplinary programs such as medical humanities. Such upper division courses might include topics such as Sociolinguistics and Latino Health, translation and interpretation in health care, and Literature and Medicine in Latin American and Spanish literatures. These types of courses would generate interest in linguistic and cultural issues while providing undergraduate student

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opportunities to engage in undergraduate research that will enhance their prospects of admissions to professional schools in the health sciences.

These recommendations represent the more immediate actions that can be taken to nurture future scholars and researchers interested in addressing questions related to Spanish in the health delivery system. Additional considerations that are beyond the scope of this report, such as the place of health related research in tenure and promotion, will certainly be necessary in order to sustain these actions in the long term.

Conclusion

In this report, I have discussed the increasingly high profile of Spanish in the U.S. health delivery system. I have argued that this high profile requires a concerted response specifically from Spanish language professionals. Current research on Spanish in the health delivery system has opened up a clear pathway for future inquiry. I have discussed some of the most clearly visible pathways within the areas of descriptive, intervention and patient-centered research. Notwithstanding the growing opportunities for Spanish language professionals to leave indelible marks on the health of Spanish speakers, there is a pressing need to promote an appropriate infrastructure for this type of research into the future. I have provided some initial recommendations while recognizing the need for subsequent leadership in the future to ensure sustainability. In closing, I think that Alonzo's view of Spanish as the Foreign National Language presents both challenges and opportunities for the future role of Spanish departments in the US academy.

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References

Alonso, C. 2007. Spanish: The Foreign National Language. *Profession 2007:* 218-228.

Angelelli, C. 2004. *Medical Interpreting and Cross-Cultural Communication*. Cambridge: Cambridge University Press.

Balcázar, H. 2009. A randomized community intervention to improve hypertension control among Mexican Americans: Using the *Promotoras de Salud* community outreach model. *Journal of Health Care for the Poor and Underserved* 20: 1079-1094.

Blewett L, Smaida S, Fuentes C & Zuehlke E. 2003. Health care needs of the growing Latino population in Rural America. *Rural Health Policy* 19: 33-41.

Bloom, M., Timmerman, G. & Sands, D. 2006. Developing a course to teach Spanish for health care professionals. *Journal of Nursing Education* 45: 271-274.

Bolden, G. 2000. Toward understanding practices of medical interpreting: Interpreters' involvement in history taking. *Discourse Studies* 2: 387-419.

Brown T, Scheffler R, Tom S & Schulman K. 2007. Does the market value racial and ethnic concordance in physician-patient relationships? *Health Services Research* 42: 706-726.

Carey M. 2015. Why Hispanic Americans still aren't signing up for Obamacare. *PBS News Hour.* Retrieved on 29 June 2015 from http://to.pbs.org/1zBbB6B

Castillo A, Giachello A, Bates R, Concha J et al. 2010. Community-based diabetes education for Latinos: The Diabetes Empowerment Education Program. *The Diabetes Educator* 36: 586-594.

Cheng E, Chen A & Cunningham W. 2007. Primary language and receipt of recommended health care among Hispanics in the United States. *Journal of General Internal Medicine*, 22 (suppl. 2): 283-288.

Chen, J., Fang, H. & Rizzo, J. 2011. Physician-patient language concordance and malpractice concerns. *Medical Care* 49: 1040-1044.

Davidson, B. 2000. The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics* 4: 379-405.

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Davidson, B. 2001. Questions in cross-linguistic medical encounters: The role of the hospital interpreter. *Anthropological Quarterly* 74: 170-178.

Diamond, L. & Reuland D. 2009. Describing physician language fluency: Deconstructing medical Spanish. *Journal of the American Medical Association* 301: 426-428.

Diamond, L., Tuot, D. & Karliner, L. 2012. The use of Spanish language skills by physicians and nurses: Policy implications for teaching and testing. *Journal of General Internal Medicine* 27: 117-123.

Dietrick L, Paxton H, Rivera A, Gertner E, et al. 2010. Understanding the role of the *promotora* in a Latino diabetes education program. *Qualitative Health Research* 20: 386-398.

Doty M, Rasmussen P & Collins S. Catching Up: Latino health coverage gains and challenges under the Affordable Care Act. *The Commonwealth Fund*. 2014. Pub. 1775, vol. 26.

Eamranond, P., Davis, R., Phillips, R. & Wee, C. 2009. Patient-physician language concordance and lifestyle counseling among Spanish-speaking patients. *Journal of Immigrant and Minority Health* 11: 494-498

Elderkin-Thompson, V., Silver, R. & Waitzkin, H. 2001. When nurses double as interpreters: A study of Spanish-speaking patients in a US primary care setting. *Social Science and Medicine* 52: 1343-1358.

Fernandez, A., Schillinger, D., Warton, M., Adler, N. et. al. 2011. Language barriers, physician-patient language concordance, and glycemic control among insured Latinos with diabetes. *Journal of General Internal Medicine* 26: 170-176.

Flores, G., Laws, M., Mayo, S, et. al. 2003. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 111: 6-14.

Garza Y & Watts R. 2010. Filial therapy and Hispanic values: Common ground for culturally sensitive helping. *Journal of Counseling and Development* 88: 108-113.

Ginde, A., Clark, S. & Camargo, C. 2009. Language barriers among patients in Boston emergency departments: Use of medical interpreters after passage of interpreter legislation. *Journal of Immigrant and Minority Health* 11: 527-530.

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Informes del Observatorio / Observatorio *Reports*. 013-09/2015EN
ISSN: 2373-874X (online) doi: 10.15427/OR013-09/2015EN

Hsieh, E. 2006. Conflicts in how interpreters manage their roles in provider-patient interactions. *Social Science and Medicine* 63: 721-730.

Isaacs, T., Laurier, M., Turner, C. & Segalowitz, N. 2011. Identifying second language speech tasks and ability levels for successful nurse oral interaction with patients in a linguistic minority setting: An instrument development project. *Health Communication* 26: 560-570.

Jacobs E, Karavalos K, Rathouz P, Ferris T & Powell L 2005. Limited English proficiency and breast and cervical cancer screening in a multiethnic population. *American Journal of Public Health,* 95: 1410-1416.

Krogstad J, Stepler R & Lopez M. 2015. English proficiency on the rise among Latinos. Washington DC: Pew Research Center.

Martínez G. 2010. Language and power in healthcare: Towards a theory of language barriers among linguistic minorities in the US. In Watzke J, Chamness Miller P & Mantero M, eds. *Readings in Language Studies: Language and Power.* Vol. 2. St Louis: ISLS.

Okrainec K, Miller M, Holcroft C, Boivin J & Greenway C. 2014. Assessing the need for a medical interpreter: Are all questions created equal? *Journal of Immigrant and Minority Health* 16: 756-760.

Ponce N, Hays R & Cunningham W. 2006. Linguistic disparities in health care access and health status among older adults. *Journal of General Internal Medicine,*21, 786-791.

Ramirez, D., Engel, K. & Tang, T. 2008. Language interpreter utilization in the emergency department setting: A clinical review. *Journal of Health Care for the Poor and Underserved* 19: 352-362.

Reuland, D., Frasier, P., Slatt, L. & Aleman M. 2008. A longitudinal medical Spanish program at one US medical school. *Journal of General Internal Medicine* 23: 1033-1037.

Reuland, D., Slatt, L., Aleman, M., Fernandez, A. & DeWalt, D. 2012. Effect of Spanish language immersion rotations on medical student Spanish fluency. *Family Medicine* 44: 110-116.

Rose, D., Tisnado, D., Malin, J., Tao, M, et. al. 2010. Use of interpreters by physicians treating limited English proficient women with breast cancer. *Health Services Research* 45: 172-194.

Schenker Y, Karter A, Schillinger D et al. 2010. The impact of limited English proficiency and physician language concordance on reports of clinical

ISSN: 2373-874X (online) doi: 10.15427/OR013-09/2015EN

interactions among patients with diabetes. *Patient Education and Counseling* 81: 222-228.

Stepler R & Brown A. 2015. Statistical portrait of Hispanics in the United States, 1980-2013. Washington DC: Pew Research Center.

Traylor, A., Schmittdiel, J., Uratsu, C., Manglone, C. & Subramanian, U. 2010. Adherence to cardiovascular disease medications: Does patient-provider race/ethnicity and language concordance matter? *Journal of General Internal Medicine* 25: 1172-1177.

Villalobos B & Bridges A. 2015. Testing an attribution model of caregiving in a Latino sample: The roles of familismo and the caregiver-care recipient relationship. *Journal of Transcultural Nursing* 26.

White, K. & Laws, B. 2009. Role exchange in medical interpretation. *Journal of Immigrant and Minority Health* 11: 482-493.

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