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Emily Vena April 9, 2019

Language and Health: Investigating Patient-Provider Communications among Puerto Rican Asthmatics (A Pilot Study)

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Abstract

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This pilot study aims to evaluate how choice and use of language within patient-provider communications affect how Puerto Rican asthmatic respondents perceive the progression of their chronic health condition. Language concordant communication in the health care setting has been cited as an influential factor contributing to overall patient satisfaction as depicted by patient compliance and intimate patient-provider relationships. In this study, self-described bilingual Puerto Ricans with chronic asthma were asked to respond to open-ended questions about their linguistic experiences while being treated for asthma in a medical setting with the expectation that the use of their preferred language in the medical setting would improve patient-provider communications as well as overall satisfaction with care for their chronic condition. However, the current set of respondent narratives revealed that language ideology, codeswitching, and institutional talk were three influential themes affecting all respondents' linguistic practices in the medical setting, as well as in daily life. In particular, four of the respondents reported bilingual medical encounters which prompted explicit analysis as well as suggestions for future research on this sociolinguistic phenomenon.

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INTRODUCTION

According to Goodwin and Heritage, "[s]ocial interaction is the very bedrock of social life", and languages, by and large, fuel interpersonal interactions (Goodwin and Heritage 1). Language is also linked to heritage and ethnic origin and is a cornerstone of both human culture and communication. Therefore, in order to assess health disparities explicitly encountered by particular groups in the United States, we must ascertain the relationships between language and health.

According to the 2011 American Community Survey, 230, 947,071 of the 291,524,091 Americans (five years or older) spoke only English at home; thus, most people in the US speak English ("Language Use in the United States" 1-3). However, linguistic disparities continue to present obstacles for those who are not English-dominant and who access health care services. Since 1980, the Pew Research Center has reported that the amount of Spanish-speakers in the US has grown by 233%. In fact, Lopez and Gonzalez-Barrera note that Spanish remains the second most spoken language in the US behind English, and Spanish-speakers account for more than 13% of the present-day population (Lopez and Gonzalez-Barrera, "What is the future of Spanish in the United States?"). In the US, 68% of individuals with limited English proficiency (LEP) consider Spanish their primary language ("KCMU/Urban Institute analysis of American Community Survey 2009" as cited in "Overview of Health Coverage for Individuals with Limited English Proficiency 2012"). The usage of "limited English proficiency" indicates the socialized standardization of English throughout the American health care landscape even though the US has never declared English its official language. As the US Spanish-speaking

population continues to grow, "demand for goods and services that meet the needs of Latinos[1] will continue to influence market trends in the United States, including health care" (González et al. 745).

However, academic inquiry regarding health care disadvantages surrounding minority identity dates back to the late twentieth century. In an inaugural effort to survey health disparities among marginalized populations, including individuals of Hispanic descent, the United States Department of Health and Human Services released the Secretary's Task Force Report on Black and Minority Health.[2] In this report, Secretary of Health and Human Services (HHS) Margaret Heckler and her Task Force discovered "a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole" (Heckler 7). The Heckler Report's findings spawn the creation of the Office of Minority Health (OMH) within the HHS. Currently, the OMH works to reveal and reduce the disproportionate health outcomes experienced among racial and ethnic minorities. A decade after the release of the Heckler Report, the OMH founded the Center for Linguistic and Cultural Competency in Health Care (CLCCHC) in order to address the need for adequate health delivery to people with LEP.

Despite the fact that the US Hispanic population has grown by a large percentage in the last three decades and despite the concerted efforts of OMH and the CLCCHC, Hispanic individuals with LEP continue to experience health disparities well into the twenty-first century. In 2006, according to Flores, the population of California—a state whose total population

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[1] Within the US, "Latino" is an ethnic identity used to describe individuals of Latin American origin. The term "Hispanic" explicitly denotes one's use of the Spanish language. For this reason, in this paper I use the term "Hispanic" because of its correlation with the Spanish language.

[2] Also known as The Heckler Report.

comprises 12% of the entire US population—was 20% Hispanic with LEP, and Flores noted that patients who experience language discordance, a phenomenon that occurs when the patient and the provider are proficient in different languages, "are less likely than others to have a usual source of medical care; they receive preventive services at reduced rates; and they have an increased risk of nonadherence to medication" (Flores 230). According to a Pew Hispanic Center/Robert Wood Johnson Foundation Latino Health survey,[3] 32% of US predominantly Spanish-speaking Latinos lack a regular health care provider compared with 22% of English-speaking Latinos. Additionally, of the 23% of the 4,013 Latino respondents who reported poor-quality medical treatment, a quarter "report their accent or the manner in which they speak English contributed to their poor treatment" (Cohn, Livingston and Minushkin "Hispanics and Health Care").

Furthermore, the data proved a correlation between linguistic Spanish-dominance and unfavorable health circumstances, and this correlation described by Flores inspired the development of this pilot study that investigates language choice and use and patient perceptions of health outcomes among Puerto Rican asthmatic adult respondents currently residing in the Metro Atlanta area. Because of Puerto Rico's geopolitical history as an American territory and the concentration of Puerto Ricans in the Atlanta metropolitan area[4], this population seemed to provide a unique linguistic-biological intersection of bilingual individuals who share a chronic medical condition that might allow an examination of how language impacts health outcomes. To address the linguistic implications of the intersection, I began with the premise that Puerto

[3] Referred to as "Pew/RWJF".
[4] "In 2014, an estimated 89,462 Puerto Ricans lived in Georgia…Georgia had the 13th largest Puerto Rican population in the United Sates…Most Puerto Ricans in Georgia (45.8%) were settled in the…Atlanta-Sandy Springs-Roswell metropolitan area" ("Puerto Ricans in Georgia" 1,5).

Ricans often display a familiarity with both English and Spanish, which may present this population with the opportunity to use either language in the health care setting. However, dual-familiarity does not rule out the possibility of a language preference or the conscious choice to communicate in either language. Thus, I was interested to see if Puerto Ricans reported discordant patient-provider communications on the basis of not using their preferred or primary language by having respondents share how they conceptualize the use of particular languages in the medical setting. Ahearn refers to these linguistic conceptualizations as language ideologies, defining them as "the attitudes, opinions, beliefs, or theories that all have about language" (Ahearn 23).

In order to gather these linguistic conceptualizations and examine their underlying ideologies, I selected a population that had frequent interactions with medical institutions by proxy of chronic illness. I chose asthma, a chronic inflammatory disorder of the airways, because it disproportionately affects people of Puerto Rican origin. According to "Asthma and Hispanic Americans", "Puerto Rican Americans have almost twice the asthma rate as compared to the overall Hispanic population" ("Asthma and Hispanic Americans"). In 2016, 8.3% of all adults in the continental US were asthmatic whereas 13.6% of all Puerto Rican American adults in the US were asthmatic ("Most Recent Asthma Data" as cited in "Asthma and Hispanic Americans"). Moreover, the Centers for Disease Control and Prevention (CDC) classifies chronic diseases as "conditions that last (one) year or more and require ongoing medical attention or limit activities of daily living or both" ("About Chronic Diseases"). Since asthma is a chronic condition, the National Heart, Lung and Blood Institute (NHLBI) suggests that asthmatic patients frequently visit allergists, immunologists, or pulmonologists. Asthmatic patients' frequency of visits can range from two-week to six-month intervals, depending on the severity of symptoms ("Follow-

up Visits: Stay on Track"). Nonetheless, the persistent nature of chronic conditions warrants long-term therapies, treatments, and greater frequency of medical consultations. Thus, asthmatic respondents would have more interactions with medical institutions than those who seek medical attention exclusively for acute complications.

Considering the social stigma associated with the diagnosis of the chronic illness also contributed to my choosing asthma. For instance, Lyons and Dolezal assert that stigmatized conditions such as Human Immunodeficiency Virus (HIV) "carr[y] a greater moral load than just chronicity and reliance. HIV 'serves as a vector through which pass many of a society's existing prejudices'" (Lyons and Dolezal 208). Therefore, people suffering from stigmatized chronic conditions are less likely to engage "with the 'medical model'", as well as respond to recruitment materials for a research study regarding their stigmatized illness (208). Because it is not often correlated with behavior and lifestyle, asthma as the chronic condition allowed for a greater possibility for recruiting respondents willing to disclose their asthmatic diagnosis. However, it is essential to note that asthma is not the primary focus of this study but rather is the mutual pathological attribute that allows participants to reflect on linguistic elements of various medical interactions within the context of chronic illness management. Thorne highlights how "communication between chronically ill patients and their health care providers has tremendous potential to be instrumental in facilitating coping, self-care management, and an optimal quality of life, or, conversely in being toxic and damaging to those ideals" (Thorne 58). The everyday difficulties associated with chronic conditions can give way to the embodiment of an identity, such as identifying oneself as an asthmatic. Due to the personal nature of chronic conditions, Thorne suggests that chronic care communications can be sorted into health-inhibiting or health-promoting interactions.

Thorne's health-promoting interactions lead one to Kleinman's illness narrative framework, a conceptual model which works to assure "that the uniqueness of illness as a human experience, in all its many social and personal manifestations, becomes the center of the healer's gaze" (Kleinman 228). Kleinman defines this type of illness narrative as

> a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings (49).

Within this framework, providers encourage patients to share individualized illness experiences and view these experiences as legitimate sources of knowledge. Since Kleinman's model privileges the collection of qualitative data derived from the experiential knowledge of patients, his framework became the philosophical blueprint from which I designed this pilot study. I intended to address patient perceptions of linguistic experiences in medical encounters by analyzing respondent answers to the following research question:

For Puerto Rican asthmatics, how does choice and use of language play a role in a participant's perception of his/her progression of a chronic health condition?

Corresponding Hypotheses:

1. For these respondents, language choice and use affect retention rates and compliance.
2. Language plays a role in the development of patient-provider relationships, particularly regarding building confidence and trust between the provider and patient.

What follows is a review of the literature that led me to develop my research question and corresponding hypotheses.

LITERATURE REVIEW

This array of discrete topics collected from the existing literature can be organized into the following four categories to reflect the fundamental conceptual components of how I synthesized the aim and design of this study: (1) linguistic and cultural concordance, (2) personal care and patient satisfaction, (3) a brief linguistic history of Puerto Rico and bilingualism, and (4) language ideology and its mode of ethnicization. The existing literature demonstrates language concordance, as well as cultural concordance, as contributing to positive patient-provider communications. When providers acknowledge patients' linguistic or cultural identities, patients report greater satisfaction with the quality of care. In discussing the participant population of this study, the combined uses of English and Spanish among stateside and island Puerto Ricans reflect the island's political history in which the dissemination of different language ideologies has resulted in linguistic repercussions that influence the linguistic practices of Puerto Rican bilingual communities.

Linguistic and Cultural Concordance

As the impact of language and culture on health was becoming more salient, on August 11, 2000, President Bill Clinton signed Executive Order 13166: *Improving Access to Services for Persons with Limited English Proficiency*. This directive aimed to improve the quality of federally-subsidized healthcare services for recipients with LEP. According to Shenk, this policy recognized language as a critical component of cultural and ethnic identity and stated that "discriminatory treatment based on language is against the law" (Shenk 104). Additionally, it recognized that language concordance, not necessarily English proficiency, was a contributing factor to the health of individuals with LEP. In fact, national probability sample data from the Pew/RWJF survey indicated that "when patient-provider language was discordant, Latinos rated

their health care lower" (González et al. 748). Thus, concordant communications were better associated with patients' satisfaction with their quality of care—when patients and providers communicated proficiently in the same language, the patient was more likely to feel fulfilled by the medical consultation.

According to González et al., "patient-provider language concordance is associated with perceptions of better and less biased health care quality among Latinos in the United States" (751). While linguistic discordance hinders effective patient-provider communication, cultural barriers cannot be overlooked either. In order to mitigate language discordance, properly-trained spoken language medical interpreters may constructively bridge gaps in patient-provider communications. However, one cannot assume they share the cultural values of the patient for whom they are interpreting. In fact, Kosoko et al. affirms that "it is unreasonable … to assume 'bilingual' to be synonymous with 'walking ethnographic encyclopedia'" (Kosoko et al. 106). In this way, patients and interpreters (and/or patients and providers) who speak the same language may each possess a diverse set of cultural beliefs. Thus, it is critical to consider how "different patients bring great variations in education, health literacy, idiom, vernacular, conceptualization and perception of wellness and illness, the existence of ethnic remedies, and notions of time and urgency to healthcare encounter." (119). A greater sense of cultural competence may provide for a clearer understanding between the patient and provider, inevitably impacting a diagnosis, prognosis and/or the delivery of care.

In a study assessing patient satisfaction and willingness to return to five emergency departments, Carrasquillo et al. concluded that Latino non-English speakers reported more problems with communication than English speakers. In fact, 52% of the non-English speaking patients were satisfied compared to 71% of satisfied English speakers. This assumes that the

primary language spoken in the data collection sites was English. On the other hand, the authors also note "that institutions serving large populations with limited English language proficiency give increased emphasis to reducing these language barriers" (Carrasquillo et al. 86). However, "all too often, rather than using professional interpreters, translation is provided by anyone who is bilingual and happens to be convenient to the scene such as family members or ancillary staff" (86). These informal communications contribute to disjunctions in communication because the interpreter "cannot place the message into the appropriate social and cultural context" (86). Likewise, in a New York City study of Hispanic patients, Seijo et al. discovered a greater amount of recall and questions asked by Hispanic patients who visited bilingual clinicians, versus Hispanic patients who saw monolingual English-speaking clinicians. The results of this study demonstrate how "language and cultural awareness have important implications in the utilization of health care services by Hispanics" (Seijo et al. "Language as a communication barrier"). Overall, language concordance and similar cultural backgrounds imply greater patient satisfaction through more active patient comprehension and interaction in the medical setting.

Personal Care and Patient Satisfaction

Both language and cultural concordance in patient-provider communications generate a more personal experience for the patient, and several researchers have contributed to this aspect of the field: Cleary and McNeil, Kleinman, Donabedian and Nápoles et al. According to Cleary and McNeil, patients report more satisfaction when they perceive their care to be more personal (Cleary and McNeil 25). Similarly, Kleinman believes the personal element of care comes from providers choosing "to organize care around the phenomenological appreciation of the illness experience and its psychological and social consequences for the patient" (Kleinman 230). This is described as the interpersonal style of care. The Donabedian model, a conceptual framework

for assessing the quality of healthcare services, also uses interpersonal as a classification but contrasts it with technical. According to Cleary and McNeil, technical care is "the application of the science and technology of medicine, and of the other health sciences, to the management of a personal health problem" (Cleary and McNeil 25). On the other hand, they state that interpersonal care encompasses the "social-psychological aspects of the physician-patient interaction" (25). The central focus of my research is the interpersonal quality of care—specifically, in regards to language use in patient-provider interactions.

In order to conceptualize the different elements of this type of interaction, Nápoles et al. developed a collection of interpersonal processes-of-care (IPC). They define IPC as "the social-psychological aspects of patient-physician interaction, such as communication, friendliness, and sensitivity" ("Interpersonal Processes of Care"). The researchers highlighted three broad elements of IPC which influence the quality of one's medical encounter: communication, patient-centered decision making and interpersonal style. These factors directly influence patient satisfaction, which Cleary and McNeil define as the "cognitive evaluation and an emotional reaction to the structure, process and outcome of services" (26). Besides these processes of care, Cleary and McNeil have also identified patient identity characteristics and structure of care as the "basic types of determinants" of patient satisfaction (25). Thus, in order to investigate health disparities, qualitative patient satisfaction data should be stratified along racial, ethnic and linguistic lines. This allows for more accurate, intersectional data in reflecting correlations between patients' identities, their attitudes regarding health services, and their respective health outcomes.

By applying Cleary and McNeil's strategy, Nápoles et al. demonstrated the mutual relationship between identity and language, and its impact on patient-provider communications,

and subsequent patient satisfaction. Their research demonstrated a negative correlation between "unclear communication (lack of clarity)" and satisfaction only among Spanish-speaking Latinos (Nápoles et al. 1339). This goes hand-in-hand with the association Cleary and McNeil have affirmed between "the amount and the clarity of information given" by the provider and patient satisfaction (29). Thus, interpersonal care, largely impacted by patient-provider communications, can be supported or inhibited by language concordance.

Linguistic History of Puerto Rico and Bilingualism

In the beginning of the sixteenth century, Spanish settlement began on the island of Puerto Rico and continued until 1899. After four centuries of Hispanization of the Puerto Rican citizenry, English was abruptly introduced to the island at the end of the Spanish-American war when Spain officially ceded Puerto Rico to the US.

Throughout the twentieth century and into the twenty-first, according to Urciuoli, "English was brought to Puerto Rico as a pedagogically, politically and ideologically liberating medium" (Urciuoli 47). In 1902, Puerto Rico's Official Languages Law proclaimed that "in all Departments of the Insular Government, in all the Courts of this Island and in all public offices, the English and Spanish languages will be used interchangeably" (Legislative Assembly of Puerto Rico "Official Languages Law" as cited in Shenk 104). Initially, in 1900, the first US Commissioner of Education, Dr. Martin Brumbaugh established Spanish as the language of instruction for first through eighth grades, and English as the language of instruction for ninth through twelfth grades. Furthermore, Maldonado states that Spanish was taught as a school subject in the latter grades (Maldonado 488). However, in 1905, Commissioner Roland Faulkner instituted English as the only language of instruction in all grade levels in the Puerto Rican public school system. Barreto states that the US maintained the "unabashed aim of promoting the

linguistic defection of its new colonial wards [Puerto Rico]" and claims that "[a]mericanization in Puerto Rico was in effect until the late 1940s" (Barreto 6). The imposition of English through policies effectively forced the Puerto Rican state, described by Maldonado as "profoundly Hispanic in terms of both language and culture," to recognize English proficiency as a necessary tool for professional, social and economic mobility (Maldonado 487).

In 1917, the Jones Act granted American citizenship to Puerto Ricans born on or after April 25, 1898, and initiated a large wave of migration from the island to the mainland. After World War II, Puerto Rican migrants were recruited and contracted as manufacturing laborers in the northeast region of the US. This period of time is widely referred to as the Puerto Rican diaspora, which led to the creation of Puerto Rican neighborhoods in states like New York and New Jersey. Today, these neighborhoods, such as East Harlem (also known as "El Barrio" and "Spanish Harlem") continue to serve as mainland strongholds of Puerto Rican culture and community.

Shenk recognizes that the "historical imposition of English" on the Spanish language of Puerto Ricans may have crafted an increased predisposition for bilingualism among Puerto Ricans than among those of other Hispanic origins (Shenk 104). On the island, Puerto Rican cultural integrity is often secured by one's maintenance of the Spanish language. On the other hand, Puerto Ricans are American citizens and English, although not the official US language, is vastly accepted as the *lingua franca* within US borders. However, contemporarily, stateside and island Puerto Ricans continue to demonstrate the linguistic legacy of the institutionalized exposure to both Spanish and English.

In her ethnographic study of language and bilingualism in *el bloque* ("the block") in East Harlem, Zentella showcases the "bilingual/multidialectal repertoire[s]" of New York Puerto

Ricans (Zentella 41). Each dialect reflects consequences of the aforementioned political and social forces imposed upon Puerto Ricans (41). Some discrete dialects include Popular Puerto Rican Spanish, Standard Puerto Rican Spanish, English-dominant Spanish, Puerto Rican English, African American Vernacular English, Hispanized English, and Standard New York City English (41). In fact, upon asking a nine-year-old respondent what language the child spoke at home, the young girl replied "'Hablamos los dos. We speak both,'…as if it was the most natural thing in the world to speak two languages and to alternate between them. [Zentella] was struck by her offhand tone and the seamless welding of Spanish and English which proved her point vividly" (1). Urciuoli, who researched language prejudice among New York Puerto Ricans in *El Barrio* asserts, that "[o]ne does not need to speak Spanish to be considered Puerto Rican, but one does need a Puerto Rican family. Nor is English a simple index of American assimilation: people can be impenetratingly 'Puerto Rican' and 'American' at the same time" (Flores, Attinasi, and Pedroza as cited in Urciuoli 78). Thus, both researchers discuss how there is no preferred linguistic identity of stateside Puerto Rican culture that would indicate a singular linguistic identity and conclude that, most of the time, both English and Spanish are regularly integrated into a customarily multilingual environment. Therefore, the increased familiarity with both English and Spanish posit Puerto Ricans as an appropriate community to study in regards to the possibility and prevalence of language choice.

Familiarity, however, denotes a wide array of dual-linguistic abilities. As mentioned above, the term "dominant" refers to the particular language in which a multilingual speaker feels most "comfortable using in terms of knowledge (e.g., vocabulary), proficiency (fluency), and confidence (ease of expression)", according to Field (58). In fact, 42% of Puerto Rican adults are English-dominant compared to the 25% of US Hispanics overall who are English-

dominant ("Hispanics of Puerto Rican Origin in the United States, 2013"). The increased prevalence of English-dominance among Puerto Ricans compared to other Hispanic subgroups further validates the observations of Zentella and Urciuoli: that Puerto Rican communities often preserve the coexistence of both English and Spanish. For Puerto Rican communicators who are familiar with both English and Spanish, the notion of dominance allows an individual to identify along a linguistic-proficiency continuum stretching from monolingualism to balanced bilingualism. Field, however, warns that it is important to note that "because proficiencies can vary considerably, all definitions of *bilingual* will be relative and perhaps subjective" (Field 16). For instance, as Urciuoli suggests, no one type of dual-language proficiency is the quintessential Puerto Rican linguistic identity. In fact, some speakers may identify as Spanish-dominant monolinguals but also exhibit low proficiencies in English. On the other hand, speakers can identify as Spanish-dominant bilinguals with elevated proficiencies in both languages. However, Field notes that "[i]n the vast majority of cases, a bilingual may favor one language over the other" which connects back to the motivations of this study with the notion of preference (58). Although rarer, at the end of the proficiency continuum exists balanced bilingualism, described by Field as "a person who is, in principle, highly proficient in both (all) the languages that he or she possesses. It is implicit that he/she is both fluent and accurate (able to speak according to native-speaker norms) in either language" (14). Overall, according to the Pew Research Center, 41% of Puerto Rican adults are bilingual, and 49% of Puerto Ricans born on the island are bilingual ("Hispanics of Puerto Rican Origin in the United States, 2013"). However, these figures do not account for dominant or balanced stratifications of bilingualism. In these cases, bilingualism may signify a comfort, familiarity or proficiency in both English and Spanish which is often fostered in Puerto Rican communities.

Language Ideology

As previously stated, language ideologies are beliefs about language and, according to Guardado, "refer to people's and communities' implicit and explicit beliefs, attitudes, and values regarding the worth of their languages" (Guardado 77). Consequently, linguistic ideologies influence the discrete language practices of individuals, and, in turn, these actions reproduce the ideology. In this section, I will predominantly summarize the contributions of Guardado, Lippi-Green, Zentella, and Urciuoli.

Guardado fundamentally asserts that "language is not only reflective of the world, but constitutive of the world" (77). He considers language ideologies to have two fundamental dimensions, stating that they are "[o]n the one hand… closely connected to processes of social interaction" and on the other that they "also refer to people's local understandings, beliefs, and assumptions about the relationship between language and social life" (56). These ideologies, i.e., the ways in which we perceive language, shape the process of linguistic socialization that frames how we acquire the values and beliefs that form our identities (62). Furthermore, Ochs and Schieffelin (as qtd. in Guardado) emphasize how "these values and beliefs are central components of linguistic ideologies and are particularly explicit in multilingual contexts" (62). Thus, individual internalizations of broader ideologies preserve group and individual identities on the basis of a language (56).

The notion of discourses becomes relevant here as well. As defined by Foucault (as qtd. in Guardado), these are "… systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak" (73). However, unlike language ideologies, discourses do not exclusively pertain to conceptualizations of language. Rather, discourse studies emphasize the contextual implications

of communications. Furthermore, Foucault and other discourse theorists posit how "control is largely maintained through ideological means—embodied in discursive practices" (72). Thus, Gee's "small 'd'" discourses, the acute acts of communication, are powerful in vindicating the status quo—the overarching "Discourse" with a capital 'D' (71). Therefore, Guardado asserts that "discourse and ideology are intimately and necessarily intertwined" because language is "political, interested, and directly implicated in power relations and in the reproduction of inequality" which contributes to the passage of discourse (77).

Lippi-Green (as qtd. in Finegan and Rickford) suggests that discourses are seized in the presence of "standard language ideology", which "provides a rationalization for limiting access to discourse" (Finegan and Rickford 293). This form of linguistic ideology is "a bias toward an abstracted, idealized non-varying *spoken* language that is imposed and maintained by dominant institutions" (293). In the US, the standard language ideology favors "white, upper-middle class, and middle American" English (294). In fact, the American educational system (including Puerto Rico) exists "at the heart of the standardization process" in the way children of varying linguistic backgrounds are mandated to attend school, but academic English is the expected language of instruction (295). Moreover, Foucault (as qtd. in Finegan and Rickford) asserts that "'[a]ny system of education is a political way of maintaining power or modifying the appropriation of discourses, along with the knowledges and powers which they carry'" (294). The mechanisms of linguistic standardization either overtly or covertly enforce "devaluation of all that is not (or does not seek to be) politically, culturally, or socially mainstream; and second, validation of the social (and linguistic) values of the dominant institutions" (294). Besides the educational system, the virtually exclusive use of English throughout mainstream American institutions reinforces a

popularized language ideology to all US habitants that English is, though not stated directly in any published legal documents, the official language of the US.

This privileging of one language in the US has been perpetuated by the English Only political movement since the 1980s. This movement offers an explicit example of US standard language ideology in that its primary demand is that of mandated English monolingualism in public institutions. The movement's linguistic ideology of formal English standardization seeks to demand what Lawton calls "cultural and linguistic unification" through the linguistic assimilation of persons who do not speak the mainstream code (Lawton 88). Moreover, Lawton states that "[p]roponents of the English Only movement contend that national unity, American identity and the English language itself are threatened by immigration and other languages, primarily Spanish, and must be protected" (79). Subsequently, the English Only movement generates a strong sense of othering to those who speak different languages. Zentella (as qtd. in Lawton) notes how this movement predominantly characterizes "the Spanish language, Spanish speakers and Latino leaders as the antithesis of their lofty English-speaking/U.S. American counterparts", thus directly subordinating the Spanish language and Hispanic identity (79). For instance, in her research in *El Barrio*, Zentella observed how

> English enjoyed symbolic domination because of its power on international, nation and local levels. Whereas English was the language of an independent and wealthy US, spread by its technologically superior media and spoken by its first class citizens, Spanish was the langue of a dependent and impoverished Puerto Rico, and of its second class citizens (108).

Finegan and Rickford add that this orientating ideology offers an extrinsic pressure for non-native and/or accented English to internalize these ideologies and assimilate or "consent to the

standard language ideology…[and]…become complicit in its propagation against themselves, their own interests and identities" (Finegan and Rickford 296).

It should come as no surprise then that the Pew Research Center reports a steady increase in English proficiency for all Hispanics since 1980. In these figures English is proficiency is defined as Hispanics ages five and older who speak only English at home or who speak English at least "very well", which professes a deeper ease with the English language and not only familiarity ("Facts on US Latinos, 2015"). In fact, in 1980 about seven-in-ten US born Hispanics were English proficient; whereas, in 2015 about nine-in-ten US born Hispanics were English proficient. These figures stand in sharp contrast to the 30.7% of foreign born Hispanics who were English proficient in 1980 and the 34.6% of foreign-born Hispanics who were English proficient in 2015. The juxtaposing English proficiencies between US born and foreign-born Hispanics demonstrate the implications of standard language ideology in the US. According to Barreto "[g]enerally, the longer a migrant or immigrant resides on the North American continent, the greater is one's familiarity with the English language" (Barreto 9).

Specifically, within stateside Puerto Rican populations, both Zentella and Urciuoli observed the institutionalization of English and the ethnicization of Spanish and its reserved uses in the neighborhood and in the home. Lippi-Green defines ethnicization, specifically of language and cultural differences as "evidence of a high-culture origin that legitimates the group's identity but does not interfere with the group making its proper contribution to the nation-state" (Lippi-Green 16). Furthermore, she asserts that "[f]oreign languages are justifiable in public places when they are used solely to reinforce the authenticity of a cultural performance" (16). In her time in *El Barrio,* Urciuoli observed few exceptions of the use of Spanish in public spaces outside of the home in "churches and community-based organizations, in bilingual education and

in the Spanish media" (Urciuoli 94). Even though these public spaces accepted the use of Spanish, they were intrinsically linked to Hispanic and/or Puerto Rican identity, not US American. Moreover, ethnicization stems from racialization that directly polarizes dominant and subordinate social groups. In the context of the US, Urciuoli observes that the "generic white American is, in semiotic terms, unmarked while the non-normative, the racialized or ethnicized person, is marked" (17). This hegemonic discourse allows for anyone who speaks a language other than English to be marked, subordinated and othered. In addition, in the US, "language difference is routinely racialized, typified as an impediment to class mobility", according to Urciuoli (16).

The assumed and institutionalized associations between English and social mobilization further encourage bilingualism in continental US Puerto Rican communities such as *El Barrio.* In this way, Zentella observed how stateside "Puerto Rican identity was being re-defined without a Spanish requirement in order to accommodate monolingual English youngsters instead of relegating them to a separate US American category" (Zentella 55). On the contrary, she expresses how "[n]early a century of struggle to preserve the Spanish language in Puerto Rico provokes many island Puerto Ricans – particularly political activists and academics – to argue that [those who do not speak and understand Spanish] are not" Puerto Rican" (53). These conflicting beliefs surrounding *puertorriqueñidad* ("Puertoricanness" or Puerto Rican identity) reflect the greater acceptance of Spanish in public spaces on the island. However, Barreto notes that "in Puerto Rico not only does the federal public sector operate in English but so do many American-owned firms that dominate the island's economy" (Barreto 7). In this way, despite how island Puerto Ricans "may identify themselves on the basis of the Spanish language, they also recognize clear rewards linked to leaning English" (7). More affluent families on the island

"send their children to study in the United States, where supposedly they will improve their [English] language skills and return with an esteemed symbol of high social status—a degree from an American university" (7). Bilingualism in Puerto Rican communities often reflects ambivalent attitudes towards English and Spanish. On one hand, the Spanish language resists neocolonial impositions and upholds cultural integrity. On the other hand, English language assimilation warrants greater prospects of economic opportunity.

Although "continental North American Puerto Ricans are exposed to the English language to a degree unseen on the island", both stateside and island Puerto Ricans recognize the symbolic value of the Spanish language and its evident connection to ethnic identity according to Barreto (9). This intrinsic, intimate association between Spanish and Puerto Rican culture stands in stark contrast to English. Likewise, Urciuoli observed how respondents in her research "live in a society that sharply objectifies Spanish and English, where English signifies the more valued language and Spanish the less valued (Urciuoli 2). Thus, notes Zentella, in bilingual communities like *El Barrio,* the use of Spanish actively rejects Americanization and preserves "the intimate 'we' of solidarity" within Puerto Rican culture (Zentella 109). However, these contained uses of Spanish in intimate communities and culturally-charged spaces further allows for the subordination of the Spanish language to English, which is "the outside 'they' language of power" (109). Overall, distinct employments of either Spanish or English in bilingual Puerto Rican communities ascribe to broader, ideological conceptions which orientate the spoken language with its given context.

METHODOLOGY

In this study, Puerto Rican asthmatic adults were interviewed. The primary and only source of data collection for this study was structured interviews. After obtaining Emory

University Institutional Review Board approval (IRB00105356) for sociobehavioral research, I began recruiting study participants, who were recruited through oral and electronic snowball sampling living in the local Metro Atlanta area. In particular, I posted participant requirements to a Facebook group pertaining to Puerto Ricans in the local area. The requirements were listed in English and Spanish in the post.

Eligible participants were 18 years or older, possessed a familiarity with English and Spanish, resided in the Metro Atlanta area, and self-identified as Puerto Rican. If interested in participating, respondents contacted me via email or Facebook messaging. From there, interview dates and times were planned. Each interview was conducted in a fairly quiet location, including bookstore and libraries. Upon meeting respondents, I introduced myself, and asked if they preferred to conduct the interview in Spanish or English. I initiated conversation in the language we had used during our electronic communications (either Facebook messaging, text messaging, or email). Most of the time, initial communications were in Spanish. Before each interview began, the participants were asked to sign a consent form detailing the features of the structured interview.

Turning on the audio recorder, I began each interview with a series of introductory questions[5] in order to comfortably ease the respondents into sharing their narratives. The opening questions were designed to familiarize myself with the respondents' linguistic backgrounds and preferences. Next, I asked participants about their earliest experiences with asthma and followed up with general questions about their condition. Subsequently, I asked questions about their experiences with treatments and the associated medical consultations. Finally, I asked participants about their personal relationships with practitioners and their perceptions of their

[5] Interview questions (in both English and Spanish) can be found in the Appendix.

patient-provider communication. At the end of each interview, the respondents were compensated with a ten dollar Barnes and Noble gift card.

All interviews were transcribed, and excerpts taken from Spanish interview transcripts are included in this paper with English translations. All identifiable information was removed from both the recordings and the transcripts. This included first names, specific occupations and exact places of residence. Pseudonyms and reduced occupation titles (student and worker)[6] were employed to conceal the identities of the study participants. All students attended the same medium-sized liberal arts university in the American South. Finally, I analyzed the data set thematically by identifying common themes and patterns across several respondents' transcribed interviews.

Fig. 1:PARTICIPANT CHARACTERISTICS[7]

Pseudonym	**Isabela**	**Carolina**	**Camila**	**Sofia**	**Mia**	**Alejandra**	**Valentina**	**Juan**
Age/Gender	38/F	21/F	20/F	31/F	21/F	57/F	29/F	21/M
Occupation Category	Worker	Student	Student	Worker	Student	Worker	Worker	Student
Where raised: Island or Stateside	Island	Island	Stateside	Island	Island	Island	Island	Island
Primary language	Spanish	Spanish	English	Spanish	Spanish	Equal in Spanish and English	Spanish	English
Linguistic identity: Multilingual or Monolingual	Multi	Multi	Multi	Multi	Multi	Multi	Mono (Spanish)	Multi

[6] Discussed below in Participant Characteristics chart and Discussion section.
[7] Participant information in this chart was derived from the introductory interview questions. A list of interview questions can be found in the Appendix.

FINDINGS

I initially sought to explore how the uses of English or Spanish may have influenced the treatment retention and provider relationship among a sample of Puerto Rican asthmatics. Throughout the eight interviews I conducted for this study, it became evident that while language is essential in medical communications, in allowing the patient to feel understood and to understand the provider, none of the participants cited language as an issue, nor did respondents explicitly describe instances of language discordance relating to language preference. However, the data did reveal three prominent, overarching themes shared across several respondents' interviews: language ideology, multilingualism/codeswitching, and institutional talk. I found that US standard language ideology, combined with physical setting, strongly influenced dichotomous linguistic practices among all respondents. These ideologies helped to regulate codeswitching—the alternation between languages—among all multilingual respondents in daily life and medical encounters. Specifically, within the medical context, asymmetrical patient-provider conversations—characterizing institutional talk—often prescribe structure to these types of communications. Therefore, a study surrounding patients' medical interactions necessitated the inclusion of institutional talk discourse. Although, I initially expected to focus on a single language use in the medical setting, the respondents who experienced bilingual medical interactions shared constructive information. Their accounts of bilingual consultations comprehensively integrated all three themes of analysis: language ideology, codeswitching, and institutional talk; as well as spawn valid suggestions for future research.

DISCUSSION

In this section I discuss how I analyzed my data across the three aforementioned themes: language ideology, multilingualism and codeswitching and institutional talk.

Language Ideology

If language ideologies determine how one perceives the social position of a language in society, according to Irvine, "to study language ideologies, then, is to explore the nexus of language, culture, and politics" (Irvine "Language Ideology"). Thus, after concluding the interviews, I began to reflect on how I viewed the use of particular languages in the medical setting and realized that my beliefs in developing this study were rooted in US standard language ideology. I had designed this project on the ideological basis that individuals who experience language discordance or limited English proficiency (specifically, those who consider Spanish to be their mother tongue), would have a difficult time navigating, or feeling satisfied with the American health care system on the basis of linguistic disparities. These linguistic ideologies are rooted in the pervasiveness of English throughout the health care landscape. The existing literature surrounding the Spanish language, US health care, and health outcomes illustrated perpetual shortcomings for patients of Hispanic heritage—especially, those who prefer to communicate in Spanish. For instance, González et al. demonstrated that language concordance affected Hispanic patients' perceptions of health care quality, rather than English proficiency

Therefore, I recruited individuals who possessed a familiarity with English and Spanish, which I believed would cause them to possess a language preference in the medical space. I was interested to see if participants who did not use their preferred language with a care provider (whether it is explicitly imposed by monolingual providers or implicitly imposed by institutionalized standards), would feel less satisfied with their quality of care. I expected

language preference to confer greater language discordance due to the detail-oriented nature of the medical space in which poor or imprecise communications surrounding symptomology or treatment can directly result in severe bodily consequences for the patient.

Upon analyzing the data, I noticed that seven of the eight respondents reported no general difficulties with language. All participants reported feeling comfortable seeking medical assistance for asthma care, and they unanimously reported no language or communication difficulties with their medical provider. It is important to remember that this study collected self-reports and anecdotal evidence provided by participants in a structured interview setting. While González et al., might describe it as "lack[ing] the level of detail of the actual clinical experience and other objective indicators of care quality", Kleinman's "illness as narrative" framework considers the patient's perspective substantial in evaluating the quality of health care delivery (González et al. 750).

As necessary as it is to reflect on my own linguistic ideologies, it is equally as imperative and interesting to consider the linguistic ideologies revealed by the respondents in their interviews. Ahearn reminds us that the Practice theory prompts us to acknowledge how "structures [both linguistic and social] at the same time constrain *and* give rise to human actions, which in turn create, recreate, or reconfigure those structures – and so on" (Ahearn 25). That being so, each respondent was predisposed to a unique set of language ideologies, and this set is continuously shaped by surrounding social environments, personal experiences, and societal norms. The data exposed the deterministic function of setting, in the ways in which different contexts accept, demand, or promote the use of particular languages, which further justifies Lippi-Green's belief that "the degree of control we have over language is limited" (Lippi-Green 5).

Throughout the interview process it became apparent that occupations directly affected how each participant conceptualized the languages in which they speak. Within the theme of linguistic ideologies, I draw from two fundamental occupation groups: workers and students. The four university student respondents, who reported spending a significant amount of time on-campus, described analogous linguistic practices in both daily interactions and medical encounters. In contrast, the four workers were classified as individuals who did not attend a US university at the time of the study. They, too, portrayed corresponding linguistic practices which were influenced by the non-campus spaces where they inhabited and interacted.

Overall, as expected, English was the *lingua franca* of the community outside of the worker participants' homes in the continental US. The worker respondents were comprised of four females ranging from ages 29 to 57 and who were raised in Puerto Rico. The four workers are represented as Isabela, Sofia, Alejandra, and Valentina.[8] They all acknowledged the widespread use of English in continental American society and its extensive use in health care facilities. For instance, Isabela was certain that her *neumólogo* ("pulmonologist") was not bilingual. Therefore, she spoke English with this provider because she felt that using English is the only way to communicate in her local US medical setting. In addition, we conducted her interview in Spanish, but after finishing and realizing that we were the only ones in the bookstore speaking Spanish, she immediately switched to English. Perhaps, she believed the setting necessitated English or maybe she became self-conscious when our conversation in Spanish amidst the silent shelves of books turned the heads of nearby shoppers. Moreover, as a Puerto Rican native residing in the Metro Atlanta area, she did not hesitate to indicate English as the primary language of her current community. Like Isabela, Sofia, considered English to be the

[8] Refer to Participant Characteristics chart for individual respondent information.

sole language of her "neighborhood" in Metro Atlanta. Both participants identified Spanish as their mother tongues and neither have consulted a bilingual provider in the states. Even though, Sofia would prefer a bilingual doctor, she has not been able to locate one in the area. Alejandra and her niece Valentina both speak Spanish at home, but considered English to be the primary language of their local community in the Atlanta suburbs. Like Sofia, Alejandra did not believe there are bilingual doctors in the area but recalled her medical interactions being in Spanish when she lived in Puerto Rico over 20 years ago. Valentina, however, has not had any medical interactions in the continental US. She considered English and Spanish to be used outside of her home but noted that few people speak Spanish in her community. Her unique inclusion of the Spanish language for an outside-of-home language may reflect her self-identification as a Spanish-dominant monolingual, with inferior abilities in English. Despite speaking some English at her job, Valentina felt more comfortable speaking in Spanish. Along with Isabela's interview, Valentina's was also conducted in Spanish. However, she specified that Spanish ensured her comprehension of the questions.

All worker respondents comprise the 72.4% of Hispanics in the United States (five years or older) who speak Spanish at home ("2016 American Community Survey" as cited in "Facts for Feature: Hispanic Heritage Month 2017"). In my study, "home" signified the respondents' current residence in the US. Once worker respondents leave their homes, they feel societal pressures to speak English. Their responses revealed a dichotomous linguistic behavior between the inside and outside of the home: Spanish being spoken inside and English on the outside. The Practice theory, which suggests a dialectical relationship between individual agency and social structures, would argue these regimented language practices are constricted by social forces, and in turn, reified by participants' actual linguistic practices. The vastly multilingual respondents

acknowledged and internalized socialized acceptances of different languages—which helps them choose which languages they speak in particular settings. They shared assumptions of the local absences of bilingual physicians but did not blatantly express concerns regarding the abundance of English in health care services. This notion confirmed their willingness to assimilate, thus, contributing to their perceptions of normalized language concordant interactions, in English with care providers and people outside of their homes.

Like the workers, the students too, revealed dichotomous linguistic behaviors and ideologies strongly influenced by setting. Also, their living accommodations contributed to the development of their language ideologies. All students are from Puerto Rico, except for one (Camila). Since these respondents are college students, they referred to "home" as the place they live when they are not lodging at their university. Therefore, "outside of home" predominantly referred to their social and academic lives while at their university in the American South. Three of the four students acknowledged English as the language of their US university life. The fourth student, Mia, identified Spanish as the language she uses at college. Since her response remains inconsistent with the others', she may avidly resist assimilatory English and maintain a Spanish-dominant social and academic life in the states while her peers do not. At home, Mia and Carolina speak Spanish, whereas Camila and Juan switch between English and Spanish. Therefore, Carolina, Camila, and Juan all expressed dichotomous linguistic behaviors in relation to the setting.

> **E:** "Which language do you speak outside of the home?"
> **Carolina:** "At home [Puerto Rico] where I was raised until tenth grade was Spanish, after that it has been English."

> **E:** "Which language do you speak outside of the home?"
> **Camila:** "Depends, I guess 'cause of [the university], English."

> **E:** "Which language do you speak outside of the home?"

> **Juan:** "Depending on the setting, here [the university] I'll almost always strictly use English. Even sometimes with my Puerto Rican friends [who also go to the university], unless I want to tell them something in private, back at home [Puerto Rico] it's all in Spanish outside of home."

Because all of the student interviews were conducted in English despite the respondents' varying degrees of bilingualism, the results of my student interviews support Lippi-Green's assertion that English is revered as the "homogenous spoken language which is imposed and maintained by dominant bloc institutions" such as the university campus, which served as the setting for each of the student's interviews (Lippi-Green 64). However, unlike any of the workers, all of the bilingual students visited bilingual care providers. Each of the student's medical consultations was bilingual because uses of English and Spanish were interwoven throughout a single consultation. All four students recalled their conversations with practitioners as switching between Spanish and English, and each language was employed to accurately convey a certain message. For instance, all noted that casual communications were spoken in Spanish, whereas specific medicalized terms (such as drug titles) were communicated in English. The alternate uses of language, also known as codeswitching, are explicitly discussed in the following section.

The preference and institutional ability to switch between languages in the medical space presented an opportunity for the students that the workers had not experienced. When the flow of conversation led me to ask, "Would you prefer a bilingual doctor?" to Sofia, she affirmatively responded, "Definitely." Since setting has been established as a key factor in regulating one's language, the students' bilingual consultations reveal spaces where Spanish and English are comparably used—places where their bilingual abilities and identities are accepted. Since three of the four students visited providers in Puerto Rico, there may be a greater proportion of bilingual providers on the island than in the Metro Atlanta area or the continental US. It also

seemed that Camila, the single student who regularly visits a provider in the states, lives in a place that is highly populated with Hispanics. Thus, Spanish-speaking providers may be more frequent in her local community. These students disclosed that Spanish was common outside of home on the island but that English still continues to permeate into island medical facilities. Instead of monolingual medical encounters in English, medical encounters on the island were characterized, which, along with notions of multilingualism, will be discussed in more detail in the next section.

Bearing in mind that my research question aimed to investigate participants' perceptions of the progression of their chronic asthma by reflecting on their treatment retention and patient-provider relationships, during the interview process, I began to realize how this motif of perception transcended the initial research question and revealed more information about one's language ideologies pertaining to accent. The connection between accent perception and the construction of language ideologies should not go unexamined. In particular, two participants expressed similar feelings regarding how their accent affects how others perceive them:

> **E:** "Have you experienced any language problems?"
> **Alejandra:** "Not really, right now I've been in Georgia for twenty years. My English is a bit better. I would say my accent, but yeah, sometimes there is some resistance in terms of your accent so people think very, very quickly, and think, 'Oh she speaks another language, I am not going to understand what she says', so there's that barrier that's going to take some time to understand. Yeah, it can be because of your accent."
>
> **E:** "How does language impact the way you speak with the doctor?"
> **Alejandra:** "It's the same thing again, my accent may be a barrier or they might not understand what I'm saying. I think that they think that they don't understand."
>
> **E:** "Have you experienced any language problems?"
> **Carolina:** "Yes, definitely, everyday. Language barriers every day, because things are just harder to do. Plus, you have an accent so people know that you're like, people are very confused…"

> **E:** "So how people perceive you?"
> **Carolina:** "People won't start talking to me and it's not like they're like 'Whoa, she's not going to understand', people are like, "So where's she from?' There's certain questions like more out there, you receive more, and there's certain questions like I don't understand what she's trying to say or people would say, my favorite one, one that I hate the most is 'Oh! Don't take her seriously, that wasn't meant to be like that, she means this.' And I'm like 'No! I mean what I said, don't put words in my mouth. I mean what I say, you're being disrespectful.' And they're like, 'You're being too strong.' And I'm like, 'I'm being honest.' But at the same time, those difficulties, I love every single of them because they remind me that I am different and it's something that I can embrace so I'm happy for them."
>
> **E:** "So you would say your language problems are not so linguistic, they're more so perception of accent?"
> **Carolina:** "Yes, I would say grammar is also a problem. Little grammar things are hard but the accent sometimes makes people not understand what you're saying which now I learned from outside of the United States, every one of us has an accent."

These two respondents described their experiences with what Lippi-Green calls "discrimination against non-mainstream accents and languages" (Lippi-Green 69). In these cases, the notion of mutual responsibility in conversation between the speaker and the listener was lost.[9] Lippi-Green states that when people "are confronted with an accent which is foreign to them, the first decision they make is whether or not they are going to accept their responsibility in the communication" (70). In these cases, she adds that "members of the dominant language group feel perfectly empowered to reject their role, and to demand that a person with an accent carry the majority of responsibility in the communicative act" (70). Alejandra is fully aware of how people perceive her accent and misjudge her fluency—both disrupting the flow of her conversations, which are stifled and squashed because people think they will not understand her due to her "ethnic" accent. These language ideologies encourage self-subjugation by causing individuals like Alejandra to believe that her accent is an immediate barrier and an abnormal

[9] Reference to psycholinguist Herbert H. Clark's cognitive model of the communicative act (Lippi-Green 70).

variation of the dominant language. Likewise, Carolina expressed her frustrations with the routine othering of her accent. She also believed that people automatically think that they will not understand her because of her grammar—which showcases what Tamasi and Antieau describe as a "prescriptive view of language rather than on language itself" (Tamasi and Antieau 63). In the health care setting, accented English may provoke the implicit biases of providers to associate a form of "impure" English with lesser authoritative or experiential knowledge. Furthermore, these assumed miscommunications can lead to adverse medical implications.

Respondents' evidenced the ethnicization of the Spanish language[10], which brought about ambivalent effects. Three of the four worker participants felt obligated to speak English with providers due to the institutionalized expectation that US health services will be delivered in English. Therefore, they exhibited assimilatory linguistic practices, but this did not directly affect their retention rate or compliance with the provider, i.e., they still felt content with their health care. This contests my first hypothesis which inferred poorer retention rates with a lack of language choice.[11] Additionally, no worker respondents mentioned distinct interpersonal elements addressed in my second hypothesis[12], but the student participants explicitly commented on the personal and cultural value of Spanish in their bilingual patient-provider communications. This leads me to believe that feelings of closeness were provoked by a unique combination of the content of communication with the Spanish language in which the content was expressed. Cultural concordance (expressed through the ethnic value of shared dialects[13]) enhances the

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[10] The ascription of the Spanish language to an ethnic identity, generally, by an outside group.
[11] "For these respondents, language choice and use affect retention rates and compliance."

[12] "Language plays a role in the development of patient-provider relationships, particularly regarding building confidence and trust between the provider and patient."
[13] Dialect is explored in greater detail in the subsequent section: "Multilingualism and Codeswitching."

significance of language concordance. Patient-provider familiarity, portrayed in students' bilingual medical encounters, represents an influential aspect of ethnicized Spanish in the positive development of patient-provider relationships.

Multilingualism and Codeswitching

Due to their proficiencies in two or more languages, multilingual individuals are inclined to codeswitch within multilingual environments. According to Tamasi and Antieau "[c]odeswitching is an alternation between two or more languages during a conversation" (Tamasi and Antieau 220). In most instances, multilingual speakers codeswitch because they feel a particular language better conveys what they are trying to say, or they want to showcase their identity. In her ethnographic research of language prejudices in *El Barrio,* Urciuoli explored where, when, how, and why study participants weaved in between English and Spanish codes. She conjectures that "[p]eople may assume one code to be normative in a particular context", which intrinsically associates with the existence of language ideologies (Urciuoli 76). She notes that "[s]ometimes the social functions of language—the ways people use language, for example, scolding, teasing, gossiping—can be done in either code or in both, code-switched" (76). Therefore, a monolingual outsider may perceive the sporadic shifts between languages as disjunctions in conversation; however, bilinguals deliberately alternate between codes to maximize comprehension of acute phrases and thoughts.

Seven of the eight respondents in this study are multilingual; therefore, the theme of multilingualism transcended occupation groupings. Student respondents were the only ones to report bilingual patient-provider communication, denoting the uses of both English and Spanish in a single medical consultation. To explicitly analyze codeswitching, students' accounts of bilingual medical encounters sanctioned another split between occupations. In my interviews, the

question, “How does speaking two languages affect your everyday life?” prompted several respondents to identify a dual cognitive omnipresence of English and Spanish. Their responses reflected how their bilingualism enhanced and limited their daily communications:

> **Camila:** “Sometimes my brain does go between English and Spanish, and sometimes I want to speak Spanish but I can’t because most people speak English here [the university] …”
>
> **Sofia:** “It’s awesome but at the same times, it makes me think twice when I’m trying to say something. It makes it difficult when I’m trying to understand. I’m taking classes and there’s some words that I may not be familiar with. But it is also an advantage when somebody else needs to have something translated and to provide that language for someone.”
>
> **Carolina:** “I guess it makes it possible for me to communicate with more people but it is also hard because there are some words that I would want to have some conversations in Spanish because I feel they would understand me better, so there’s still a little bit of a language barrier because I am thinking in Spanish and English at the same time.”
>
> **Juan:** “It can sometimes cause a bit of confusion, especially when you’re trying to look for particular word choice you have a way of expressing. I’ve always found in Spanish it’s a lot easier for me to express emotion and more like feelings than it is in English. But, when I want to describe something in particular, I find English should be a bit more precise.”

During the predominantly English interviews, respondents referred to specific words in Spanish which demonstrated their parallel lexicons:

> **Mia:** “I went to a *neumólogo* [“pulmonologist”] and he basically just me do the breathing thing and diagnosed me with asthma…”
>
> **Juan:** “Yes, it’s like this mouthpiece with like a *tubo* [“tube”], and then you attach the albuterol that you can just take…”
>
> **Juan:** “At the time, in high school, so there’s this thing called *Polvo Sáhara* [“Saharan Dust”], I don’t know if you’ve heard about it before…”
>
> **Juan:** Yeah, I’ve gone to a clinic, my parents, a practice, and there’s this other doctor I go to. He has his own practice, *pulmonólogo* [“pulmonologist”].”

Mia and Juan are both student respondents who visited providers in Puerto Rico. Perhaps, their instances of codeswitching reflect how they have regularly heard these words and phrases expressed in Spanish.

There were noteworthy inconsistencies between what some respondents identified as their primary languages in contrast to the languages they speak at home. Bilingual participants like Camila and Juan, reported an even use of English and Spanish to be the language(s) used at home. Juan noted at home he is "always switching between languages" and that one language has never been used more than the other. Yet both students identify English as their primary language. On the other hand, Alejandra did not believe she had a primary language at this time, but she predominantly speaks Spanish at home. These inconsistencies contribute to the deep comfort these individuals feel communicating in either language if they are pressured to speak one over the other in certain contexts.

As Tamasi and Antieau state, "language is an inherent and integral part of human identity", and in this way, bilingualism or multilingualism are linguistic identities (Tamasi and Antieau 19). One's ability to use certain languages in certain contexts is not only a reflection of their language ideologies but also a reflection of how they identify socially and culturally. In stateside-born Puerto Ricans, the maintenance of Spanish has been shown to increase one's overall "Puertoricanness." Camila exemplified this ideology by admitting,

> "There's always this communal thing, I don't want to assume he's [pediatrician] Puerto Rican, but at least with us Puerto Ricans, it's like you're Puerto Rican, I'm Puerto Rican, we've got each other's back type of thing. That's one thing that connects us, so if we're speaking in Spanish it helps us, I don't know how to explain it but you just see when you're able to communicate with someone in a language that they identify with, it's just like a different experience. It's like you get me, you understand…"

Besides the direct instances of codeswitching during the interviews, the theme arose when student respondents recalled the customary codeswitching that occurred in their health

consultations. The data revealed an ideological schism in the way each language was employed in bilingual patient-provider communications—which displayed an association between codeswitching and language ideologies. All student respondents acknowledged English as the language of medicine, largely spoken in a formal and official tone. Spanish was depicted as the language of personal care, and added greater affection and ease to the session. To such a degree, workers also recognized English as the language of medicine—as the primary language of the stateside health care system. Despite reporting Spanish as her primary language, Isabela assimilated into the English-dominant system. It is plausible to assume that she speaks English in the health care setting as a means to maximize the quality of services delivered to her:

> **Isabela:** "*Maybe* hay cosas que si hablar en español, pudiera explicar a él [neumólogo] mejor, aunque no es un asunto que me de trabajo y puedo hablar en inglés con el medico, pero hay cosas, es que la lengua primaria es más fácil de explicar que hablar en el otro idioma, aun cuando domino ambos."
>
> **Isabela (English translation):** "Maybe there are things that if I were to speak in Spanish, I could better explain to him [pulmonologist], although that's not an issue that causes me trouble and I can speak to the doctor in English, but there are some things, it's just that explaining in your primary language is easier than in an other language, even when I am proficient in both."

The students who bilingually communicated with their providers mentioned what Urciuoli describes as distinctive and normalized "code boundaries" in patient-provider conversations (Urciuoli 76). Collectively, their experiences indicated a shared linguistic boundary between formal, more medicalized verbiage in English; and casual, personalized speech in Spanish. As Urciuoli states, "In these cases, a sense of distinction between English and Spanish becomes important" because it explicitly affects speaker meaning and listener comprehension (76). Likewise, to bilinguals, each language possesses a conceptualized function where "one code may specifically heighten the function by making the scolding more pointed,

the play funnier, the gossip more biting" (76). Among bilinguals, there exists a deliberate divide in how and when each language is used in English/Spanish patient-provider exchanges.

According to student respondents, providers introduced intricate kernels of medical terminology in English. Providers then turned to Spanish to allow this information to blossom with increased comfort. English medical jargon was complemented with culturally-competent, regionalized dialects of Spanish. The use of Spanish in bilingual health encounters effectively facilitated patient comprehension and enriched the patient-provider relationship. Providers spoke in Spanish to offer demedicalized explanations and ascribe to local communication styles. For examples, excerpts from the interviews with Camila and Mia demonstrate these explanations:

> **Camila:** "He's a pediatrician, he's bilingual, he's Puerto Rican. Actually, well, I know he's Hispanic but my mom[14] has a tendency of acting like I'm not in the room when she's there so she'll talk to him for me, so usually it'll be a Spanglish type of ordeal. I think she uses Spanish sometimes just to feel like more comfortable, so that she feels that… or if he uses Spanish, sometimes he'll use simpler terms than in English 'cause I am assuming he learned all his medical terminology in English. So he uses Spanish sometimes to simplify it for her."

> **Camila:** "I think that he [pediatrician] will try to use his medial jargon and then he will try to break it down into English and them from English then he goes to Spanish. I think he will put the most important stuff in Spanish like 'this is the thing you have to get.' I think also what might be a thing is that a lot of his patients are Hispanic as well, and some of them don't even speak English."

> **Mia:** "No, he [pulmonologist] would refer to his phone, to the dictionary of the diseases or conditions in English, and then explain to me in Spanish and vice versa."

> **Mia:** "Well he [pulmonologist] will start explaining in Spanish or English, and then he will say 'this antibiotic is not going to help you with asthma', and then he will pull up the phone. He's more of a teacher, he teaches me, so he opens it up and reads it all, and then goes to Spanish and explains it to me."

[14] Camila's mother usually accompanied Camila to the doctor. Therefore, Camila's accounts of patient-provider communications almost always included her mother and her mother's linguistic influence.

Both Carolina and Juan expressed the importance of cultural context and the impact of sociolinguistic variation. They referred to their local dialects as "lingo":

> **E:** "How does language impact the way that you speak to the doctor?"
> **Carolina:** "There are things because we are from the same communities, there is a lot of lingo that we use that wouldn't be understood even if it was another type of Spanish doctor."

> **E:** "How does language impact the way that you speak to the doctor?"
> **Juan:** "If it's [communication with provider] in Spanish, I can use local sayings and phrases that I know he'll understand, like lingo, but if I were to say those exact sayings, maybe a direct translation in English with somebody over here [in continental US], it would make no sense whatsoever."

> **E:** "How does language impact the way they [the provider] speak to you?"
> **Carolina:** "It's more casual because they know how to communicate with it [lingo]."

> **E:** "How does language impact the way they [the provider] speak to you?"
> **Juan:** "I think if especially back at home [Puerto Rico], if they resort to English, or they're trying to explain something to me in English, it's very, I guess you could say professional and not using any lingo, and very proper vocabulary and word choice. And when I go to Spanish, it's a lot more fluid interaction and they can use phrases, and they can joke around and have a bit more of a personable experience with me being the patient."

The discussion of dialects and indexical phrases provoked Juan and Carolina to acknowledge the vast quantity of Spanish dialects. Mutual Spanish dialects can generate effectual patient comprehension and overall satisfaction. For example, Juan did not stress the need for a Spanish-speaking doctor; he did, however, require the provider to possess a certain cultural competence:

> **Juan:** "especially with Spanish where there's a lot of different versions, dialects. If I know that they [provider] have a Caribbean background, I know that there's things that I can say that they'll understand. If they speak Spanish, but they're from Spain or South America or Central America, there will be things that I will say that they don't understand and there will be things that they say that I won't understand."

> **E:** "How does language impact the way you speak to the doctor?"

> **Carolina:** "There are things because we are from the same communities, there is a lot of lingo that we use that wouldn't be understood even if it was another type of Spanish doctor."

In conjunction with Seijo et al., both respondents corroborated the robust need not only for language, but also, cultural congruity between patients and providers.

Institutional Talk

Institutional talk is the notion that social institutions organize and inform social interaction and that these regulated interactions, in turn, reproduce the institution's particular socialized functions. For example, according to Heritage and Clayman, medical institutions "plainly antedate the lives and actions of the persons who participate in them. But these institutions do draw life from, and are reproduced in, those actions" (Heritage and Clayman32). Thus, as patients, study participants assumed institution-relevant characters (i.e., "patient and "doctor"), and the interaction was implicitly scripted by macro-social expectations about the given space (i.e., the doctor's office). Medical facilities, figuratively and physically, reinforce the dichotomous discourse identities of patients and providers. Specific features of the Westernized medical setting such as white coats, waiting rooms, and prevalence of technology distinctively create this space; but, also reproduce society's standards of how a medical facility should operate.[15] It is generally accepted for patients to strip down to underclothes, sit on examination tables, and wait for the provider to arrive to help them (upon arrival, providers typically sit in conventional chairs). These structural features enforce the societal expectations surrounding asymmetrical authority in patient-provider dialogue.

[15] Reference to Kathryn V. Staiano's *Interpreting signs of illness: a case study in medical semiotics.*

In a standard patient-provider consultation, discourse identities are produced and reproduced through the traditional flow of interaction. There is a socialized standard for how patients and providers should communicate in these designated spaces. Therefore, when interpreting medical encounters, Goodwin and Heritage note that "[t]he identity assumed by one party is ratified, not by her own actions, but by the actions of another who assumes a complementary identity towards her" (Goodwin and Heritage 292). The patient willfully assumes a subordinate social position by initially seeking the provider's superior knowledge, and later accepting the provider's prescriptions. Like language ideologies, dichotomous patient and provider comportments are perceived as the status quo. Though, the characters' internalizations of these roles boost the provider's authority in the conversation, and distance the two characters, affectionately.

Since discourse settings and identities are critical topics to consider within the institutional talk framework, Heritage and Clayman urge conversation analysts to ask "Why that now?" when interpreting instances of institutionalized speech. I asked that question when student respondents described explicit occasions of codeswitching during their bilingual medial encounters. How did context, characters, and intended message warrant the use of a particular language during a bilingual exchange? Heritage and Clayman recognize discourses "within a continuum of social contexts: private versus public, formal versus informal, and professional versus bureaucratic" (2). In particular, the student respondents, who exclusively experienced bilingual medical interactions, evidenced an attenuation of institutional talk from formal to informal. However, the informal interactions seemed to conflict with the formal institutions in which they occurred; as well as with care providers—whose occupations conventionally assert formality. Thus, these respondents' reports of bilingual medical encounters muddled the

"dividing line between ordinary conversation and interaction that is professional, task-focused, or 'institutional'" (Heritage and Clayman 2).

I did not observe any patient-provider communications, nor did I chiefly configure my research around the domain of institutional talk. However, through listening to respondents' testimonies, specifically to the accounts of bilingual medical visits, I noticed how the use of Spanish had seemingly diluted the rigid structure of institutional talk. Even though medical spaces automatically impart a standard of institutional talk, the use of Spanish in bilingual medical interactions effectively blurred the boundary between ordinary conversation and institutional talk. When I discussed the theme of language ideology in the Literature Review, I mentioned the dichotomous ideologies during these encounters that prompted instances of codeswitching. Collectively, respondents revealed their beliefs about the association between English and formal, medicalized content whereas Spanish was used to convey more casual messages. For instance, student participants depicted uses of Spanish as mimicking "ordinary conversation." The codeswitching implications of distinctive language ideologies appeared to shift the patient-provider conversations along the continuum—stretching from the most formal institutional talk to the most unprofessional ordinary conversations. Although Heritage and Clayman do not "propose any hard-and-fast distinction between 'ordinary conversation' on the one hand and 'institutional talk' on the other", there is something to be said about how and why Spanish was used, and what it represented in English-Spanish bilingual consultations (2). In some sense, the use of Spanish on the part of the respondents may have been motivated by a desire to regain a sense of social power as the level of institutional talk was diminished when participants communicated in Spanish, and some symmetry was restored between the respondent

and the provider because, figuratively speaking, the provider's white coat rested on the back of his/her chair when the two conversed in Spanish.

In these cases, the symbolic value of the white coat, which irrefutably accredits the doctor's epistemic authority, is hidden behind their ordinary identity. The cultural and ethnic values of Spanish are presented at the forefront of the provider's identity, which forms a mutual connection with the patient. Inevitably, the nature of the setting (i.e., an examination room) lays a foundation of institutional talk, and the setting imposes a significant amount of control over the dialogue. According to respondent's bilingual encounters, Spanish reduces the ideological distance which traditionally manifests itself between the patient and the provider. In these types of medical encounters, the shift from English to Spanish mirrored a shift from disease narrative to illness narrative.

Kleinman's profound validation of illness narratives[16] expresses how institutional talk encourages patients to focus on the physical and biological symptomology of health conditions. He rejects synonymy between the terms "disease" and "illness" but rather asserts that the provider is trained to be obsessed with the crude, physical symptomologies characterizing the nature of a disease. Whereas, patients' daily managements of symptoms characterize the social experiences of illness. According to student respondents, the use of English was riddled with medicalized jargon, which clearly ascribes it to the disease model. According to Kleinman, the jargon results from the exchanges when the provider interprets "the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic

[16] I cite Kleinman because I am interested in the symbolic difference between illness and disease. Other works on illness narrative include Rita Charon's *Narrative medicine: honoring the stories of illness,* Susan Sontag's *Illness as metaphor; and, AIDS and its metaphors,* and Arthur W. Frank's *The wounded storyteller: body, illness, and ethics.*

entity…" (Kleinman 5). In students' interactions, providers used Spanish to untangle the convoluted terminologies into information the patient could better comprehend.

Spanish possessed a significant amount of cultural capital as respondents reported feeling more personally-connected to providers who spoke the localized Puerto Rican dialect. The cultural salience of the illness experience was better expressed in Spanish than in English. In the context of these bilingual medical interactions, respondents related the disease model to English, and the illness model to Spanish. Institutional talk gives way to the dichotomy between disease and illness, which influences linguistic practices in English-Spanish bilingual communications. These practices reproduce and reiterate language ideologies that impose the institutionalization of English and the ethnicization of Spanish. This ideological dichotomy rationalizes instances of codeswitching, even in settings which innately impose a standard of institutional talk.

CONCLUSION

In this section I reflect on my research process and identify the limitations of this study. Subsequently, I provide a review of my results and key findings. Based on the study's limitations and findings, I offer suggestions for future related research.

Reflections and Limitations

I attribute my inability to explicitly answer my research question to a variety of limitations that start with the design of the study and end with data collection. One of the most significant limitations in this study is its small sample size due to time constraints (in completing the entire study) and credentials (in the recruitment of participants), and the nature of this being a pilot study. Another limitation is the high percentage of balanced bilingualism (versus dominant bilingualism) demonstrated by study participants. This led to most respondents not having a

strong preference for one language and feeling completely comfortable communicating in Spanish or English. Initially, I believed participants would be more scattered along the "bilingual" spectrum rather than most possessing almost-perfect bilingual capabilities. Likewise, another explanation is the participants' extensive educational opportunities and professional careers. For instance, Alejandra believed her health-related knowledge (derived from her professional background) was of greater influence to what a doctor prescribed her rather than the use of a particular language or her "evident" accent. Additionally, all respondents were avid supporters of undergraduate education and research due to their experiences with higher education: Alejandra works at a university (upon seeing the respondent eligibility requirements, she was quick to "snowball" recruit her niece, Tatiana), Isabela is a scientist, Sofia is an engineer and the four students are currently enrolled at a liberal arts research-driven university. Therefore, their personal experiences with and appreciation for education motivated them to participate in the study. In turn, their enthusiasm effectively skewed the sample demographic to vastly reflect an abundantly-educated and virtually balanced-bilingual population.

Furthermore, recruitment materials emphasized basic eligibility requirements to participate in the study but neglected qualifications which could have affected overall consistency of collected data. It would have been useful to include in these materials a requirement for stateside health care experience. In fact, all of the students and one worker respondent recalled experiences on the island. Therefore, upon analysis, the data was greatly stratified to accommodate the varying locales of participants' narratives. Additionally, various interview questions directly pertaining to language usage and comfort were designed to elicit open-ended responses yet in actuality yielded yes/no responses. Therefore, these compact responses did not meet the initial expectations for how much information would be cultivated in

order to sufficiently address my research question. Additionally, the questions exclusively about asthma were methodically asked as structured decoys to allow the respondents to familiarize themselves with me as the interviewer and permit me to organize the narratives shared and the course of the interview. However, most patients shared more information about their asthmatic condition and less about their linguistic abilities and/or struggles. This may be due, in part, to the specific inclusion of asthma in the eligibility requirements.

The method of data collection ironically served as a limitation to the scope of my data. My identity, as an ambitious yet naïve undergraduate student as well as a non-native Spanish speaker absolutely affected the results of my data collection. It is definitely worth noting that two of the interviews were conducted in Spanish. Even though immediately upon meeting the respondent, I asked which language they preferred to chat in. For most interviews, I would ask this preliminary question in Spanish. Due to my preexisting language ideologies surrounding Spanish-subordination to English-domination. As Urciuoli suggests, "my use of Spanish did not fit my 'white' persona" (Urciuoli 74). Some participants thought I was Puerto Rican possibly due to the color of my hair, but my unequivocally Caucasian complexion warranted others to ask me about my ethnicity and my inspirations as a researcher. It seems appropriate to include Juan's anecdote about how people perceive his exterior: "…especially back at home [Puerto Rico], usually people approach me thinking I'm American because I'm not, I guess, the traditional *puertorriqueño,* with my clear eyes and my skin is very light skin so there I always have to turn it around [to speak Spanish]".

While conducting her research, Urciuoli describes the difficulty she experienced when trying to explain the reasons for her data collection to participants, and while mine was not as extensive, I experienced similar hurdles in conveying my research purpose to the participants.

Urciuoli explains it in the following way: “The central problem was how to represent what I was there to study…To me this was a natural object of study. To most of them it was not: if nothing were wrong with the way they spoke, why study it?” This relates back to the yes/no responses. Most of those questions were designed to prompt participants into revealing linguistic struggles, concerns and deeper thoughts about their language behaviors. However, their evident assimilation into English-dominant institutions or bilingual aptitudes made way for the mundane reception of those stimulating questions—questions that were deliberately designed to answer the research question. Instead, most participants focused on the prevalence of asthma in their families, which treatments they received and why they believed they have asthma. Upon further analysis, I felt I had generated excessive “word waste”, i.e., words I had collected from participants but could not use in my analysis. Although this information does not directly contribute to how I would answer my research question, it does allow the patient-centered motivations of this study to flourish and to follow Kleinman’s “illness as narrative” framework.

Interviews are inherently social settings, and I am neither Puerto Rican nor a member of the Puerto Rican community in Metro Atlanta. As Briggs notes, (qtd. in Ahearn) “[l]inguistic anthropologists strongly maintain that meanings emerge in specific social interactions, and interviews are no exception… the interviewer is a co-participant in the interaction, and this can have an enormous effect on what is said, how it is said, and why it is said” (Ahearn 57). As mentioned earlier, participants made assumptions about my identity and the language I would speak based on my appearance, and I believe this played a role in what kinds of information were shared with me. Besides electronic exchanges to plan the interview, another limitation was that we were strangers to one another. Unlike traditional ethnographic research, I had not been imbued in local communities except the Facebook group I had joined before and during the

recruitment process. The physical settings of interviews and their associated confounding noises were contextual factors which limited how much information was shared with me. For instance, an interview conducted in my car was quiet, but offered less space and comfort than did an interview in a slightly louder bookstore setting with padded chairs and open space.

Even though I intended to exclusively collect the words of respondents through interviews, I identified self-report data as the final limitation of this study. González et al. note similar concerns when they state:

> We relied on patient self-reports, which lacked the level of detail of the actual clinical experience and other objective indicators of care quality (egg, medical outcomes). "In-depth mixed design studies (i.e., qualitative and quantitative) may be needed to accurately depict the qualities of communication during clinical encounters related to patient-provider language concordance and to relate those qualities to health outcomes and health care use (750).

Summary

Findings showed that US standard language ideology, codeswitching as an effect of multilingualism; and institutional talk are three themes which impacted the respondents' interactions with medical providers. Specifically, language ideologies presented an ideological frame for how languages were to be used in certain contexts. Additionally, Lippi-Green concludes that linguistic ideologies ethnicized the Spanish language and English with traces of Spanish in it. Respondents revealed their conceptualizations regarding English as the language of institutions (including medical institutions) and Spanish as more cultural and casual code. In particular, four respondents reported bilingual medical encounters. Among these respondents, linguistic ideologies influenced how and when codeswitching occurred in the medical

consultation, which, in turn, reduced the level of institutional talk—all the while enhancing patient-provider communications and cultural cohesion.

Suggestions for Future Research

Since pilot studies are intended to be small-scale preliminary studies, an obvious suggestion would be to increase the number of respondents. Furthermore, the initial expectations for this pilot study were to recruit participants with varying capacities in English and Spanish communications. In vast majority of participants said they felt proficient in either language. I had originally focused on the use of one language in the medical setting and did not acknowledge the use of two. Personally, I believe the four balanced bilingual participants[17] who experienced bilingual medical encounters shared the most fruitful and inviting data for future studies. With that said, this study warrants more research about balanced bilinguals, who feel a strong comfort with both English and Spanish, and their experiences navigating the American health care system—specifically, the semantics and psycholinguistic instincts of codeswitching in bilingual encounters.

Asthmatic participants did not hesitate to disclose their asthmatic identity because it is a less shameful chronic condition. I expected the chronicity of the condition combined with this notion of minimal shame to provoke a greater frequency of medical interactions among participants (Lyons and Dolezal). However, respondents reported asthma control and did not feel they had to consult medical attention more than a few times a year. In future research, the scope of participants with chronic conditions should be widened to include more stigmatized conditions[18]—conditions which necessitate frequent medical attention and ones that patients

[17] Throughout the study these respondents were frequently categorized as student respondents.
[18] Chronic conditions are often associated with lifestyle behaviors. Thus, implying the possibility for robust psychosocial effects.

cannot "control". It would be interesting to see how other chronic conditions facilitate or impede instances of codeswitching due to cultural sensitivities surrounding the given condition. In order to have participants share more about their linguistic identities and experiences, my findings suggest more preliminary ethnographic fieldwork and greater awareness of the ideological implications of each question. Additionally, a wider scope of participants of varying Hispanic identity subsets, ranging in bilingual proficiency, socioeconomic status, and occupation type will produce more generalizable data. Despite the smaller sample size and inadvertent deviation from my research question, the findings of my pilot study extend the need to research the social junction of language and health.

APPENDIX

Interview Questions (English)

Introductory questions:

1. What is your first name?
2. Would you prefer to conduct the interview in English or Spanish?
3. Can you tell me your age, gender and occupation?
4. Where are you from?
5. Where do you live now?
6. Which language do you use more often at home?
7. Outside of home?
8. Do you consider yourself multilingual?
9. If yes, between which languages?
10. Do you consider one language to be your primary language?
11. How does speaking two languages affect your everyday life?
12. Which language is used more in your community?

Questions addressing retention hypothesis:
(Personal experience with asthma)

13. Tell me about your experience with asthma
14. When did you experience asthma for the first time? What happened then?
15. If you went to see a *helper or healer or care provider* [19] of any kind, tell me about your visit and what happened afterwards.

[19] The word that they employ here (i.e. "doctor" or "pulmonologist") I will continue to use when prompted with [insert person] is included in the following questions.

16. How does asthma affect your everyday life?
17. According to you, what caused your asthma? (primary causes)
18. Are there any other causes that you think played a role? (secondary causes)

(Perception of treatment)

19. Tell me about your experience with asthma treatment
20. What kinds of facilities do you go to for asthma care?
21. How often do you visit a [insert person] for asthma?
22. When you have visits for asthma, do you visit the same [insert person]?
23. Do you listen to this [insert person]?
24. What language do you speak with the [insert person]?
25. Which language did they use? Are they bilingual?
26. Does the [insert person] ever switch between languages?
27. Does the [insert person] listen to you?
28. Are there any times when you have felt that the [insert person] did not understand you?
29. Did you understand the [insert person] when they recommended your treatment?
30. What treatments did you expect to receive for asthma that you did not receive?
31. If you did not understand or choose to follow the [insert person's] orders, did you ask family or friends for advice about asthma care?

Questions addressing relationship hypothesis

32. Have you experienced any language problems?
33. Do you feel like you were heard better by [insert person] using one language or the other?
34. Do you feel comfortable seeking medical help with asthma?
35. Do you need to feel a sense of compassion with the [insert person] that you see?
36. If you repeatedly visit the same [insert person], do you trust this person?
37. When you first sit down, do you start speaking to your doctor in Spanish or English?
38. Have you ever hesitated to ask a question to a [insert person] because of the presence of the language you want to use?
39. How does language impact the way you speak with the [insert person]?
40. How does language impact the way they speak to you?

Interview Questions (Spanish)

Preguntas preliminares:

1. ¿Cuál es su nombre?
2. ¿Inglés o español?
3. ¿Me puede indicar su edad, género y ocupación?
4. ¿De dónde es?
5. ¿Dónde reside ahora?
6. ¿Qué lengua usa más frecuentemente en casa?
7. ¿Y afuera?
8. ¿Se considera multilingüe?
9. Si sí, ¿en qué lenguas?
10. ¿Cree que tiene una lengua primaria?
11. ¿En su vida diaria, cómo le afecta el uso de 2 lenguas?
12. ¿Qué lengua se usa más en su comunidad?

Hipótesis de retención:

(Experiencia con asma)

13. ¿Me puede compartir su experiencia con asma?
14. ¿Cuándo experimentó asma por la primera vez? ¿Y que pasó después?
15. ¿Si visito un *especialista de cualquier tipo*, me puede describir la consulta y que pasó después?
16. ¿Cómo su asma le afecta su vida diaria?
17. ¿En su opinión, qué causó su asma?
18. ¿Cree que había otras causas?

(Percepción de tratamiento)

19. ¿Me puede compartir su experiencia con el tratamiento de asma?
20. ¿Dónde va para cuidar su asma?
21. ¿Con qué frecuencia se va al [insert person] por su asma?
22. ¿Cuándo va al [insert person], visita a la misma persona?
23. ¿Sigue sus consejos?
24. ¿Qué lengua habla con el [insert person]?
25. ¿Qué lengua habla el [insert person] con usted? ¿Es bilingüe?
26. ¿[Insert person] varía entre lenguas?
27. ¿El [insert person] le escucha?
28. ¿Ha sentido a veces que el [insert person] no le comprendía?
29. ¿Comprendió el [insert person] cuando le comunicó el tratamiento?
30. ¿Anticipó tratamientos pero no recibió?
31. ¿Si no entendió o siguió los consejos del [insert person], les pidió consejos a los parientes o amigos?

Hipótesis de relación paciente-médico:

32. ¿Ha experimentado dificultades con la comunicación?
33. ¿Se siente que el [insert person] le escuchó mejor cuando usted habló en una lengua particular?
34. ¿Se siente cómodo/a buscando atención médica por su asma?
35. ¿Usted necesita que el [insert person] exhibe compasión?
36. ¿Confía en esta persona?
37. ¿Cuándo visita al [insert person], comienza hablar en español o inglés?
38. ¿Alguna vez ha decidido no preguntarle algo al [insert person] por las dificultades de comunicación?
39. ¿Cómo afecta la lengua el modo en que habla con el [insert person]?
40. ¿Cómo afecta la lengua el modo en que el [insert person] le habla?

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