Distribution Agreement

Danna Torres March 25, 2025

Healthcare Disparities through a Dual Lens: Hispanic Patient Experiences and Physician Perceptions in the U.S. Healthcare System

by

Danna Torres

Dr. Xochiquetzal Marsilli-Vargas
Adviser

Department of Anthropology

Dr. Xochiquetzal Marsilli-Vargas

Adviser

Dr. Karen Stolley

Committee Member

Dr. Kristin Phillips

Committee Member

2025

Healthcare Disparities through a Dual Lens: Hispanic Patient Experiences and Physician Perceptions in the U.S. Healthcare System

By

Danna Torres

Dr. Xochiquetzal Marsilli-Vargas
Adviser

An abstract of
a thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Science with Honors

Department of Anthropology

2025

Abstract

Healthcare Disparities through a Dual Lens: Hispanic Patient Experiences and Physician Perceptions in the U.S. Healthcare System

By Danna Torres

This ethnographic study examines the relationship between Hispanic patients and healthcare providers in the United States, exploring how frameworks of individual responsibility shape physicians' perceptions of Hispanic health disparities and perpetuate structural inequalities in healthcare delivery. Through semi-structured interviews with thirteen self-identified Hispanic individuals and nine physicians from various medical practices, the research reveals a significant disconnect between Hispanic patients' clinical experiences and physicians' perceptions of how Hispanic communities are served within medical institutions.

The study challenges the Hispanic Health Paradox—the epidemiological finding that Hispanic Americans tend to have better health outcomes despite lower socioeconomic status and barriers to healthcare access—by presenting Hispanic participants' lived experiences that demonstrate systemic failures rather than individual shortcomings. Findings indicate that physicians have been conditioned to self-regulate within existing healthcare structures, limiting possibilities for structural reform. The research argues that habituation and power dynamics have led physicians to consistently employ narrow cultural and structural frameworks that maintain the current healthcare system, while Hispanic participants' accounts not only demonstrate resilience in the face of health inequality but also offer critical perspectives on systemic barriers embedded in a for-profit medical system.

Healthcare Disparities through a Dual Lens: Hispanic Patient Experiences and Physician Perceptions in the U.S. Healthcare System

By

Danna Torres

Dr. Xochiquetzal Marsilli-Vargas
Adviser

A thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Science with Honors

Department of Anthropology

2025

Acknowledgements

To Dr. Marsilli-Vargas. Thank you for all your time, patience and support throughout this research project. When reading your academic work for the first time, I was inspired by your dedication and passion to the study of circulation of health discourses within Hispanic and Indigenous communities. Your work has solidified and opened up new possibilities for my future academic career as an anthropologist. Since our first meeting, you have encouraged me to follow my passions in serving my community through research. Believing in me gave me strength and courage to tackle any obstacles I encountered and taught me to be resilient in the face of the unknown. For that I will be forever grateful.

To Dr. Stolley: “‘The best thing for being sad,’ replied Merlin, beginning to puff and blow, ‘is to learn something. That’s the only thing that never fails’”—T.H White, The Once and Future King. This small quote you gave me was why I decided to undertake this research project. You made me realize my love for learning and that my wants, needs, and passions should always come first. Thank you for all your support and time spent here at Emory. I have always loved and appreciated our conversations, which have grounded me as we try to make sense of the world, the good and the bad.

To Dr. Phillips: Thank you for your time and support in this research project as a committee member. I appreciate and admire your expertise in the ethnographic anthropological field and your advice on moving forward in my academic career has been invaluable. Thank you!

To my Interview Participants: Thank you for trusting me with your personal stories. I admire your resilience and strength in the face of mistreatment, loss, and uncertainty. You have inspired me to further advocate and support my community for a better future. I also want to thank everyone who has helped me recruit participants for this study.

To the Anthropology Department Staff: Thank you, Dr. Paul, Langston Jenkins, and Heather Carpenter, for organizing and supporting this year's honors cohort.

To my family and friends: Thank you for always being there for me through your support and kindness. Thank you for all your faith and love throughout this journey. Love you all. ¡Gracias ma por tu apoyo y sacrificios que me han llevado a donde estoy hoy, te amo!

Table of Contents

CHAPTER ONE

INTRODUCTION

“Para mí el sistema médico de los Estados Unidos no sirve, está quebrado, porque, aunque hay doctores muy, muy buenos, de muy buena ética, hay otros doctores que realmente no les importa la salud de las personas, solo sacar dinero de las aseguranzas.”[1]

Before making this statement, Amanda shared her recent negative experience seeking and receiving medical care in the U.S. She was born in Mexico but has lived in the U.S. for over 30 years. In all those years, she had only seen a doctor when she had to give birth to her three children and when she was in danger of losing her life. Her experience included long waits, misdiagnoses, and a lack of empathy from some health care providers. I remember her looking at me in disbelief as she told me that the healthcare system was so broken that there were as many "good doctors" as there were "bad doctors”. The possibility of encountering a doctor who could care less whether you live or die, as long as you have the insurance to pay for it, is the reality that the participants in this study revealed to me.

Amanda's statement alone has given us a glimpse into the lack of trust between Hispanic[2] individuals and the U.S. healthcare system. Her testimony represents the sheer frustration and

---

[1] For me, the United States medical system is useless; it's broken. Although there are very, very good doctors with very good ethics, there are other doctors who really don't care about people's health, only about making money from insurance.

[2] I chose to use the term 'Hispanic' throughout this paper because most of my participants have self-identified using this term. To maintain consistency and accurately represent their chosen identity, I will adhere to their preferred terminology.

exhaustion with a system in which millions of dollars have been invested; she is not the only one with the same frustration and exhaustion with the U.S. healthcare system. However, only a few high-income countries, such as the U.S., have demonstrated a high and consistent level of dissatisfaction with their health care system. In 2022, "health care spending in the United States reached $4.5 trillion and increased 4.1 percent, a faster rate than in 2021." (Hartman et al., 2024, p.16). However, despite the enormous spending on health care, "the United States performs poorly compared to other high-income countries in areas such as health care coverage and [...] improved health outcomes at the population level" (Papanicolas et al., 2018, p.1025).

Differences in health outcomes and spending between the United States and other high-income countries can be seen in 2016, when "the United States spent 17.8% of its GDP on health care (range across countries, 9.6%-12.4%; mean of all 11 countries, 11.5%) (Papanicolas et al, 2018, p. 1027). Despite the United States being one of the highest income countries in the world, the National Center for Health Statistics (NCHS) reports that "U.S. life expectancy will continue to decline in 2021, with the largest increases in mortality occurring among U.S. adults aged 25-54." (Masters et al., 2023 p.26). Why is it that we are one of the few countries in the world that invest so much in its health care system and yet have higher rates of mortality and health problems? Is the low performance in healthcare and health outcomes experienced by everyone equally?

To understand the high level of healthcare dissatisfaction in the country, I turn towards the Hispanic community and practitioners themselves. When asked why some doctors tend to appear almost robotic, as multiple Hispanics have described in their experiences, where they only allocate 5-15 minutes of attention to the patient, Dr. Langford stated:

> “I don't. I don't know if that happens as much. I think. What does happen is that people dread the visits because they take too long. If you have to have an interpreter. It's going to take twice as long. It's not that they mean to be robotic; it's that they have 15 minutes slotted for this person, which means they're actually gonna be able to say, like, three things. Yeah. And that's really hard. But. And I think what ends up happening is people; what's perceived by the patient is like the frustration and impatience of the doctor.”

Statements made by Dr. Langford and other physicians sometimes contradict the perceptions and experiences of Hispanic individuals during medical visits. There is no doubt that minorities, such as the Hispanic community, encounter multiple forms of barriers and disparities within the health care system. Several studies have demonstrated disparities in access to health care within various minority groups in the United States (Hall, 1998; Lee et al., 2013; Nickens, 1991). Among the minority groups that suffer from these health disparities, health research shows that Hispanics conduct "fewer ambulatory visits to the physician office than whites, and are less likely than whites to receive screening for colon cancer, high cholesterol, and high blood pressure” (Gresenz et al., 2009, p. 1542). Several factors have impacted the ability of the Hispanic population to actively participate in the U.S. healthcare system. Some primary contributing factors have been correlated with income, particularly insurance, which requires individuals to meet a certain income threshold and make monthly or annual payments. While income, race, ethnicity, and geographic location have played a role in limiting access to health care services, little research has been conducted to analyze how physicians have self-reflected on their roles as caregivers toward minority groups such as Hispanic communities. Particularly, how might physicians' self-perceptions influence systemic inequalities within the U.S. health care system? What can this tell us about how the health care system works?

Project Overview

The purpose of this ethnographic study is to gain a broad understanding and insight into what members of the Hispanic community in the United States experience when accessing health care services. This study argues that individual responsibility frameworks—similar to those used in discussions of the Hispanic Health Paradox (analyzed in detail later)—have shaped physicians' perceptions of Hispanic health disparities within the U.S. health care system, ultimately reinforcing disparate treatment. While the experiences of Hispanic patients challenge the validity of the Hispanic Health Paradox, they also highlight the need for a shift from an individual responsibility framework to a more systemic one; one that does not place blame on individual behavior, but rather acknowledges the structural disadvantages embedded in a for-profit medical system.

This study consisted of interviews with thirteen self-identified Hispanic individuals who have interacted with the U.S. healthcare system. In addition, to analyze the relationship between Hispanic individuals and the U.S. healthcare system, I interviewed nine physicians from different medical practices to better understand both parties' perspectives on similar issues and experiences within medical consultations and healthcare disparities.

It is important to note that I chose to focus on the Hispanic community because of my deep interest in exploring the disparities in health care utilization within this minority group. The

Hispanic community has historically been subjected to numerous forms of discrimination, prejudice, and exploitation from a variety of sources within the United States. Hispanics who have immigrated to the United States are often more vulnerable to these injustices due to their lack of fluency in English and, in many cases, their undocumented status. In addition, Hispanics are often more vulnerable to political and public disputes over forms of health care access, as they are often portrayed as "freeloaders" who are somehow taking advantage of an already flawed system.

Before proceeding, I would like to position myself within this ethnographic research. The field of anthropology has come a long way from its colonial roots (Hammersley, 2006) as it has reformed itself as a valuable form of study to examine the complexity and interconnectedness of human societies. To be more precise, ethnographic research has been reformed and re-evaluated as a method that "often involves asking ourselves and others questions about possible motivations, beliefs, explanations, and consequences of actions" (Duranti, 1993, p. 214). Academics and students like me have explored and considered various ways to approach communities and the analysis of research topics ethically, while still allowing these communities to have their voices heard. My goal is not only to give voice to the voiceless, but also to consider different histories, outcomes, and factors that contribute to health disparities within this community.

No ethnographic researcher can capture every nuance within and between different groups of people or systems. I am no exception, but my responsibility as a researcher is to disclose where I stand on this highly complex topic in order to understand the limitations of my findings and data collection. I grew up identifying as the daughter of Hispanic immigrant parents in Dallas, Texas, a city known for its diverse immigrant population and constant political tension over immigration issues. As a result, I was bound to hear conversations, sometimes too young to fully understand, between my family members about their experiences of being looked down upon because they could not speak English properly, or their concerns about how a new law might jeopardize their eligibility for benefits. Unable to graduate from high school, my mother and her younger siblings immigrated from Mexico to the U.S. in hopes of a better future. However, as the years went by, my family often struggled financially, especially when it came to affording proper medical care. I am fortunate to have been born a U.S. citizen along with my brother. At the same time, my older sister and mother were fortunate enough to become citizens, which meant we were all eligible for healthcare assistance, such as Medicaid. Despite being able to use Medicaid, we often faced various barriers to seeing a doctor, including location, doctor availability, and cost. As I continued my studies for higher education, I found myself thinking more about health access in my community.

The more I grew up, the more confused I was when my uncles or my mother would talk about how doctors generally don't care whether we live or die. As I progressed in my education, I struggled to understand how doctors, who were sworn to help those in need, could fail to do just that. When I reached my junior year of college, I considered becoming a doctor, thinking that I would be the exception and not treat patients the same way my family and friends had been treated, but the more I learned and was exposed to different aspects of the healthcare system academically, the more I began to see its limitations, especially its failures towards minority groups. As an undergraduate senior at Emory University, I had access to resources that helped me better understand what healthcare workers face within the limitations of the healthcare system. Therefore, my experiences with the healthcare system and the exposure of other people's experiences have influenced my interests and research methods.

I initially approached this research with the intention of exploring the role that language plays in facilitating communication or creating mistrust between Hispanic individuals and their health care providers. Language differences have often been an obstacle that many patients and physicians face during consultations. I understood that although healthcare organizations emphasize allocating resources to help more non-speaking patients be easily understood by their healthcare providers, such efforts are limited. Language is a crucial tool for communication, especially when it comes to understanding someone else's pain and experience with their own body, but it can also be subject to preconceived assumptions about an individual's way of life (i.e. linguistic ideologies). I was particularly interested in analyzing these unconscious assumptions based on someone's language because they can create mistrust between these two groups, resulting in bad care for the Hispanic community.

My research began with open-ended questions for both Hispanic patients and physicians about language use, available resources, and their experiences during consultations. As a bilingual Spanish-English speaker, I was able to engage deeply with Hispanic individuals to understand the emotional and cultural nuances in their responses. After conducting initial interviews with Hispanic patients, I became interested in the Hispanic Health Paradox—the epidemiological finding that Hispanic Americans tend to have better health outcomes than non-Hispanic whites despite lower socioeconomic status and barriers to healthcare access.

As my interviews with both groups progressed, I observed a significant disconnect between Hispanic patients' clinical experiences and physicians' perceptions of how Hispanic communities are served in medical institutions. While the physicians I interviewed acknowledged healthcare inequalities and external factors affecting Hispanic access to care, deeper analysis revealed their discussions of health disparities were often limited and fragmented, mirroring academic debates about the Hispanic Health Paradox. This observation led me to two key research questions: How do frameworks of individual responsibility—similar to those used in discussions of the Hispanic Health Paradox—shape physicians' perceptions of Hispanic health disparities within the U.S. healthcare system, and how do these perceptions perpetuate structural inequalities in healthcare delivery?

To answer these research questions, the next chapter will provide historical context through several key areas. First, I'll examine the history of insurance and its impact on healthcare access in the United States. Second, I'll explore the historical exploitation and mistreatment of Hispanic populations in agriculture. As history has shaped Hispanics' positions within different institutional systems in the country, it is essential to understand these histories to fully grasp the current challenges Hispanics face in accessing healthcare in the United States. Third, I'll analyze the Hispanic Health Paradox, with a particular focus on the declining health outcomes observed in immigrant Hispanic populations over time, in order to understand the perceptions of health within this community among academic scholars, researchers, and physicians. Finally, to contextualize systemic racism and inequality within medicine, I'll introduce concepts of power dynamics and colorblindness that support my research findings.

My analysis reveals significant patterns in how Hispanic patients and physicians perceive health disparities within the U.S. healthcare system. The findings demonstrate that physicians have been conditioned to self-regulate within existing healthcare structures, effectively limiting possibilities for structural reform. Furthermore, habituation and power dynamics have led physicians to consistently employ narrow cultural and structural frameworks—similar to those seen in academic discussions of the Hispanic Health Paradox—which maintain the current healthcare system. Conversely, Hispanic participants' accounts not only demonstrate resilience in the face of health inequality and structural failures but also challenge the very existence of the Hispanic Health Paradox through their lived experiences and structural perspectives.

CHAPTER TWO

METHODS

As previously mentioned, I had initially decided to focus on the language landscape and its influence on perceptions between the patients and caregivers. I was interested in understanding how physicians and Hispanic patients perceive language differences and understanding. Less than half of physicians in the United States speak more than one language (Ortega et al., 2023, p. 1098); therefore, it is to be expected that not all Hispanic individuals will have access to a Spanish-speaking doctor when receiving care. Physicians are expected to work with the patient and the resources available to give information and treatment properly. For Hispanic individuals whose first language is not English and who most likely grew up in a different cultural context, there is a chance that they may have reservations of physicians and the healthcare system that may influence the care they receive. Although my topic has shifted to physician self-perception and roles in the healthcare system, my initial topic of interest has influenced how I collected data.

Sampling: Hispanic Participants

Semi-structured interviews were conducted in this study to understand the relationships between physicians and Hispanic patients. To be exact, I planned to obtain two sample groups to conduct the semi-structured interviews. One consisting of physicians and the other of self-identifying Hispanic individuals. Given that I was focused on language differences initially, obtaining participants whose first language was Spanish was key. Additionally, I had aimed to target older Hispanic generations ranging over 40 years, given that there was a higher chance that their first language was Spanish, and they had more experience navigating the United States healthcare system.

Unfortunately, acquiring a reliable source to recruit Hispanic participants presented a challenge. Most Hispanic organizations or groups I had contacted were reluctant to support research involving their members. Reluctancy to participate may stem from the fact that Hispanic communities have often been exploited and mistreated in the country. It was reasonable for individuals to be uncomfortable sharing such personal experiences with someone they had never met. I did not want my research to put anyone under stress or fear; therefore, I decided to take a different approach to recruiting. It would be more effective to inform individuals who knew of me or were recommended to me by acquaintances within and outside of Emory University to participate in the study. Those who self-identified as Hispanic would be asked in person or through a third party individual if they would be interested in being interviewed or if they knew any additional family members or friends willing to participate. This recruitment method was more effective because it allowed a form of trust between willing participants and me; given that a close family member, friend, or acquaintance would ask for their participation, the more likely they would feel comfortable disclosing their experiences with me.

This research aimed to conduct interviews with 8-10 Hispanic participants from September to December 2024. By the end of December, I had recruited 13 willing Hispanic participants, comprising eight females and five males. Although my initial goal was to interview older adult Hispanic participants, given my access to recruiting a more consistent sample, participants ranged from the early 20s to the 60s. All interviews were conducted through Zoom or in person at an agreed-upon date and time. After obtaining oral consent from the participants, they could opt out of audio recording and instead have written notes taken. However, all Hispanic participants consented to audio recording. A week after an audio recording was transcribed, the recording was then permanently deleted. All information was stored under a locked desktop computer, and files were stored to protect patient confidentiality. To protect the identity and privacy of Hispanic individuals who participated in the study, their names will be replaced with pseudonyms. Other information, such as age, country of origin, state of residence, or occupation, will be disclosed unless participants did not disclose or request the omission of this information.

Before starting every interview, I would introduce myself in English or Spanish, depending on the Hispanic participants' preferences, and conduct the interview while speaking one of the two languages or both, as needed to maintain the conversation's flow. I also prepared a set of pre-written questions to guide the discussion for all Hispanic participants. The pre-written questions fall under five categories: origin, language, health experiences, opinions of U.S. healthcare, and insurance. The questions of origin aimed to gain a better understanding of the cultural, financial, and linguistic context of a participant's experiences that they had disclosed. Questions involving language consisted of asking individuals about their fluency in Spanish and English, and whether they have had difficulty navigating the health system if they have trouble speaking English fluently. After understanding their fluency, I came up with questions that asked more about personal experiences when they were dissatisfied with care or unsure of treatment. In their responses, I would then ask about their insurance availability and their opinion of the quality and function of having insurance. Lastly, I would ask individuals for any concluding thoughts on what should be done to better access the Hispanic community and what has been a constant issue that they have seen since living in the United States.

It is important to note that even though I had constructed questions for every interview with Hispanic patients, I was open to discussing any topics participants brought up. This led to the omission or addition of questions during the interviews to allow for a more fluid conversation. It also allowed Hispanic participants to discuss specific topics that they felt were important to disclose and express their feelings about certain aspects of healthcare that have influenced the quality of care. As I started to conduct more interviews, specific topics that seemed consistent with other interviewed individuals emerged. The consistency of topics also pushed me to bring up specific questions in different interviews. Having done more than half of the Hispanic interviews in September and October, I had simultaneously been working on recruiting physicians to participate in the study.

Sampling: Physicians Participants

I had initially struggled to reach out to doctors across the Atlanta area, as clinics and hospitals often don't disclose physicians' work email addresses or phone numbers to the public. I would have had to call the clinic directly, explain my research, and ask if one of their doctors would be available for a 30-minute interview. I understood the possibility of the clinic being allowed to disclose information about its staff was low, so I took another approach. An acquaintance of mine had worked at a nearby clinic supported by Emory University, and they informed me that their emails can be found using their first and last name. That opened the possibility of reaching out to the physicians at this clinic and within the Emory School of Medicine. The Emory School of Medicine has numerous staff members with extensive experience in medical practice who also serve as instructors to current medical students. Luckily, the School of Medicine did provide staff with email information. I had reached out to a handful of professors who would be interested in participating or if they could point me to someone who would be willing to help. Fortunately, I received an email from one of the professors at the School of Medicine. They recommended contacting the new assistant dean of Equity, Engagement, and Belonging. After reaching out and meeting to discuss my goals for this research, they were more than happy to assist me in recruiting physicians at Emory Medical School.

I constructed an overview of the information regarding physician participation. I sent it to the assistant dean so they could create a concise and effective mass email to be sent to every department in the medical school. The email informed willing participants that the interviews would be a one-time occurrence, lasting approximately 30-45 minutes, with the option to meet in person or use Zoom, depending on their convenience. I stated the research purpose: to understand the relationship between Hispanics and doctors, given the language landscape, and to find out their opinions regarding health inequalities. Fortunately, I received email responses from physicians who were more than happy to participate in my research. Ultimately, I conducted nine interviews with physicians working in various medical practices in Atlanta, Georgia. I initially considered narrowing down the medical practice that participants would have to work on, but I decided against it to better have a grasp of different aspects of the healthcare system.

As with Hispanic participants, physicians could choose whether the interview would be audio-recorded or written down by hand. After receiving oral consent, all physicians were willing to have audio recordings during the interview, and after a week of transcribed recordings, the original audio was deleted. To maintain the same level of privacy and confidentiality for Hispanic participants, all audio recordings of physicians' interviews were stored on a password-protected computer and in password-protected folders, and physicians' names were replaced with pseudonyms. Physicians also had their own set of open-ended questions for the interview. The questions aimed to understand their practice, environment, and the time they can dedicate to patients. Additional questions were asked to determine how they interpret health disparities within the Hispanic communities and their reasoning and opinions behind these health outcomes. At the beginning of my interviews, I asked doctors about their evaluation of how language interpreters and other resources affect the quality and understanding of most consultations with Hispanic patients who do not speak fluent English. In addition, asking them about the communication between themselves and their clinics with third parties like insurance or other organizations that provide services to their patients. However, it's essential to note that these questions were not always asked in interviews, as each physician drove the conversation differently. To ensure that I gathered enough information, I omitted and added new questions on the spot, given that interviews were mainly only 30 minutes instead of close to an hour, as was the case with those involving Hispanic patients.

LIMITATIONS

The conclusions from this research are, in fact, limited by the time constraints and recruitment methods employed. As mentioned, when I began this study, I intended to explore the language landscape in greater detail. By the time I had shifted my topic of interest, some interviews had already been conducted with pre-written questions. Therefore, there is some inconsistency in the discussions of certain topics with participants as I progress with this study. The time limit to recruit and interview all participants for this study was just under 4 months. Due to this time constraint, the number of interview participants is relatively small, making it difficult to generalize the experiences and opinions of all who identify as Hispanic or physicians. Additionally, due to the limited time needed to recruit as many participants as possible, there is a disproportional imbalance between male and female participants, where females are more likely to be dismissed by physicians in the healthcare system. Given that most Hispanic participants were female, it is uncertain if their disclosed experience was a result of biases due to sex, ethnicity, or both compared to their male counterparts in this study.

Findings from physician participants' interviews are limited due to the wide variety of medical practices that exist within the interview participants' sample and the health system in the United States as a whole. Not all physicians work under the same available resources, policies, and environment; therefore, it can be assumed that not all physicians agree with or follow similar beliefs or biases. My commitment to respecting physician participants' available time has ultimately limited the amount of information I could gather compared to that of Hispanic participants. Most interviews with physicians lasted around 30 minutes, which limited my ability to delve deeper into specific topics.

Suggestion For Future Research

Both groups of participants, Hispanics and physicians, have no direct past or present encounters with each other, and I was never present in physician consultations with any participants. Therefore, I am limited to understanding the thought process and witnessing the discussion taking place among all parties present within the consultations/experiences that were disclosed to me. It is essential to note that individuals may overlook certain details that could be insightful in understanding physician practice, patient comprehension, and perceptions during consultations. As individuals' body language and tone of voice can often tell a different story compared to verbal communication between individuals. I believe future research efforts should incorporate a more observational approach where the researcher is able to sit in on doctor consultations and follow up with patients and physicians with semi-structured interviews. Being able to get the perspective from a Hispanic patient's experience with a doctor and following up with the same physicians from their perspective might give more insight into how both parties understand their role in consultations and how they implement it into practice.

Furthermore, Hispanic ethnicity encompasses a diverse range of cultures, languages, and practices that this study's sample size is unable to fully incorporate. To obtain a well-represented conclusion on Hispanic community navigation, understanding, and perception within the U.S. healthcare system, a larger participant sample is required, comprising a diverse range of Hispanic individuals with varying country of origin and age. Alternatively, future research can instead focus on a particular category that falls under a certain nation, location, language, cultural practice, etc, for results to be more focused and specific to a particular group of people. Lastly, to gain a more refined understanding of the healthcare system, it would be beneficial to focus on specific medical practices to recruit and interview physicians, given the diverse methods of practice within healthcare.

CHAPTER THREE

HISTORICAL REVIEW

Medical Insurance

To understand the position of the Hispanic community within the U.S. health care system, it is crucial to understand its structure and the historical context that created it. Paloma has lived in the United States her entire life and has worked preparing food for a Southern state college for over 10 years. She and her daughters can communicate in both English and Spanish. The interview began with a discussion of her relative experience with her primary care physician. We then moved on to discussing insurance, and she was very open to discussing her financial situation regarding access to health care services. I asked her if she had been uninsured at any point in her life, and she responded.

> No, I didn't have it. When I used to go to the clinic when I was pregnant, I would qualify for half the price. Like I would pay 13, 15, 20 dollars for my birth control. Yeah, but never free, really. In Parkland and I had one at Baylor, and when I went to the doctor's visit, I had to pay one hundred. By the time I had her [her daughter], I would be paid. It would be paid off. I had insurance, but that was my like my co-pay. That was my part. Insurance paid so much, and then I paid so much. And that was my pay 100 a visit.
>
> I used to get it [insurance] at work, and I didn't really like it because I had a lot of trouble for one year. I think it was Cigna or something I was paying, and I wasn't even registered, and I couldn't get him to give me my money back. But that's when COVID hit. So, I wound up paying one thousand something for nothing, and I lost that money.

Health insurance in the United States has been a recurring topic in political conversations. Many recent political leaders have discussed implementing an efficient form of national health insurance within the country to alleviate health disparities. However, efforts to build a national health insurance system have historically faced backlash and obstacles from various groups. In the early 1900s, no government programs offered support for access to health services, and insurance companies had not considered a business in ensuring health (Quadagno, 2006). The Progressive Era emerged in the United States, tackling the "same problems that gave rise to socialism—harsh working conditions, unemployment, urban poverty, and labor unrest—but the remedies were reformist rather than revolutionary" (Quadagno, 2006, p.18). As a result, many groups formed to support improving conditions within the working class.

The American Association for Labor Legislation (AALL) was one of the first to implement methods to improve workers' health. They aimed to pass a bill that "would provide workers with free medical services and hospital care, sick pay, and a modest death benefit" (Quadagno, 2006, p.19). The AALL Bill created the first plan for implementing national health insurance to provide workers with free medical services. Multiple states considered implementing the bill within their state government, with some succeeding. However, many physicians in states considering passing the AALL bill opposed it, as it left the payment methods for physicians up to medical opinion. In addition, many commercial insurers opposed the bill as they feared it would "undermine the private market for life insurance and funeral benefits and eventually lead to a government takeover of all industry products" (Quadagno, 2006, p.20). Less control over the health industry would have left insurance providers fewer opportunities to increase their profits. To discourage states from passing the bill, commercial insurers convinced U.S. society and prominent organizations that the AALL bill would be the first step toward a communist society and, therefore, a threat to their freedom (Quadagno, 2006). The significant pushback the AALL bill received prevented it from being further implemented throughout the country.

In addition to AALL's efforts for national health insurance, political campaigns like Theodore Roosevelt's made it "the central plank in its platform, support for national health insurance" (Boychuk, 2008, p.26). However, several other parties and campaigns opposed the idea of offering provisions for health services across the country. The opposition to national health insurance was rooted in the effort to "maximize the influence of whites in the South and, simultaneously, the influence of the South in national politics" (Boychuk, 2008, p.23). The South in the early 1900s had integrated segregation across all areas of the healthcare system in their states, where hospitals prioritized the white population by providing better care and access to health services. As the U.S. government began to discuss the New Deal and, within it, the concept of having equal access to health services, the South perceived it as a threat to their institutions and racial order. The southern political leaders and the government then agreed to a compromise that domestic workers, primarily composed of people of color, would be "excluded from eligibility for contributory pensions. A second compromise was that social assistance and unemployment insurance be administered by the states, which would determine eligibility and levels of benefits" (Boychuk, 2008, p.28). The second compromise gave each state the power to continue discriminating against African Americans and other people of color by limiting their access to health services and quality of care.

Giving states the power to decide who is eligible for certain health benefits has had the effect of severing a form of consistency and health equity for many vulnerable populations. Minority populations are then at the mercy of their state government, historically known to cater to the white population, to decide if they are eligible for certain health benefits or if they will have to bear the financial burden of their health. As states regulate health care coverage and benefits, health insurance companies are becoming increasingly involved in the third-party process of accessing medical services. Insurance companies often need to communicate between clinics/hospitals and patients to determine whether the insurer will cover medications or treatments. The healthcare system must then follow the growing insurance and pharmaceutical industry to keep hospitals, clinics, and other healthcare facilities operating effectively.

Health insurance in the United States is crucial when navigating the healthcare industry. The type of insurance determines the financial burden a person will face when seeking health services. Some insurance providers may offer co-payment as a method of coverage where the patient pays a fixed amount, “for a covered health care service after you've paid your deductible.”(*Copayment - Glossary*, n.d.). However, co-pays can vary between different insurance providers depending on their policies on specific exams, the number of doctor visits, medicine, etc. It’s important to note that policies in insurance plans are not stagnant but constantly change over time through the insurance providers' evaluation of cash flow, shareholders' interest, the number of consumers, and more. Therefore, patients must obtain health insurance and be on a plan that can meet their medical needs while alleviating the financial burden.

There are multiple ways to acquire health insurance in the United States; some acquire it through their company jobs, and others may take it upon themselves to seek private health insurance providers. Most insurance companies in the United States operate in a transactional relationship with patients, job companies, and the government. According to *The Anatomy of Health Insurance,* “Oftentimes, the flow of funds is more roundabout: governments or employers nominally pay insurers, but these costs are then passed on to individuals, via increased taxes or lower wages." (Cutler & Zeckhauser, 2000, p. 566). Despite having different methods to acquire health insurance, there are restrictions in place that limit these options.

A common restriction factor is income; as mentioned previously, patients who sign up for insurance plans must pay a certain amount monthly/yearly, not only by deducting their wages but also through taxes. Individuals are then inclined to change and seek out insurance plans that cause less financial stress. But by changing plans, patients can "experience more interruptions in their care and are less likely to establish ongoing relationships with their physicians" (Sohn, 2016 p. 182) and stay on plans that do not fully meet their medical needs. This results in having large, fixed pay for utilizing certain health services. In addition, "many policies impose further cost sharing through caps on various types of expenditures. For example, policies may permit 8 mental health visits per year" (Cutler & Zeckhauser, 2000, p. 576). The U.S. government, however, has imposed certain restrictions on insurance providers regarding life and annual limits that no longer allow people to pay if they go over a specific dollar limit on coverage for essential health benefits (Affairs (ASPA), 2013).

According to the U.S National Health Interview Survey (HHS) "The nation's uninsured rate declined significantly in early 2023, relative to 2020, reaching an all-time low of 7.7 percent for U.S. residents of all ages in the first quarter (January-March) of 2023,“ (Affairs (ASPA), 2023, "Key Findings" section). However, studies have shown that most people who are not insured have been minority groups. Specifically, "[g]reater insurance loss accounted for almost three-quarters of the disparity between Hispanic and non-Hispanic whites" (Sohn, 2016, p. 198). All minority groups experience a prominent number of uninsured individuals after the age of 30, but for Hispanic communities, being uninsured is notable across all ages. Distinct factors have influenced this significant disparity between Hispanics and their white counterparts. This may be due to Hispanic individuals not having citizenship. Being a non-U.S. citizen restricts individuals from applying for health insurance because some require specific documentation that can only be obtained through citizenship.

Hispanic individuals who do have health insurance are the majority under Medicaid, as many Hispanics are unable to get affordable private coverage through their employers. Medicaid is "one of the largest U.S social programs, currently providing health insurance coverage to 73 million Americans." (Currie & Duque, 2019, p.148). Medicaid is a prominent insurance program which supports low-income families in receiving necessary medical services. It operates under the same eligibility policy, but states can make alterations to the Medicaid program and "are not obliged to cover all healthcare screenings/tests and treatments that a patient may need unless the procedures are approved by the Federal Drug Administration (FDA) or deemed non-experimental." (Jones, 2006, p.53). Therefore, there is no guarantee that if a person can obtain Medicaid, their health needs will be met without spending large amounts of money. Since each state receives limited funding to support the program, efficiency and quality of care are not constant throughout the country.

A Quick Overview of the Hispanic Community and Its Struggles

A participant named Pedro has lived in the United States for about 30 years and has worked several manual labor jobs over the years. He shared that he was young when he first arrived in the United States and that he initially struggled to communicate both outside and inside a medical health setting due to his lack of English language skills. Over the years, he told me that he eventually learned English and what to expect when seeking health care in the United

States. He expressed his distaste for the health care system in the U.S. compared to Mexico when it comes to providing care to those who are undocumented. As he talked about the failure of the U.S. to provide health care, he shared a personal story as an example,

> Por ejemplo, le platico un caso, yo conocía a un amigo. ¿Que él tiene que ir a diálisis, ¿verdad? Porque tenía problemas con sus riñones. Entonces él no tenía ni un seguro porque era indocumentado.
>
> Entonces les dijeron en el hospital público, "ven aquí y si alguien no vino. Te podemos dar diálisis, pero si todos vienen no podemos dar diálisis porque es un costo carísimo", es carísimo la de diálisis. Entonces él, pues él, desafortunadamente murió por…porque no, no le pudieron dar diálisis, entonces es como estamos hablando de que hay personas que tienen su problema y no tienen seguro y son indocumentados, pues también tienen derecho a la salud, ¿verdad?[3]

It is not easy to disclose the passing of a friend when their death could have been avoided, and I am grateful that Pedro trusted me with his friend's story. Unfortunately, these outcomes are not rare in the United States. However, Hispanic communities have shown resilience and often maintained a strong sense of well-being in the face of injustices and discrimination.

Their constant resilience has been a source of strength, but it has also been tested in many ways. In Hispanic communities' external factors have increased their exposure to chronic illnesses, especially in the general workforce and particularly in the agriculture industry in the United States. The states with the "largest Latino migrant farmworker populations are California,

---

[3] For example, I will tell you a case: I knew a friend. That he had to go on dialysis, right? Because he had problems with his kidneys. So, he didn't even have insurance because he was undocumented.
So they were told at the public hospital, "Come here, and if someone doesn't come. We can give you dialysis, but if everyone comes, we cannot give dialysis because it is very expensive." dialysis is very expensive. So he, well, he, unfortunately, died from... Because, no, they couldn't give him dialysis; therefore, it's like we're talking about it. There are people who have their problem and do not have insurance, and they are undocumented; well, they also have the right to health, right?

Texas, Florida, Washington, Michigan, Oregon, North Carolina, and Georgia" (Jones, 2006, p.259) are known to have harsh weather conditions that pose a higher health risk to those who work in the industry not to mention being exposed to harsh chemicals. Throughout the 1900s and 2000s, Hispanic farm workers have been the subject of exploitation through the lack of safety measures within the agriculture industry. Farmworkers have faced "numerous environmental threats to their health, including chemical hazards such as pesticides […]and biological hazards, such as inadequate access to drinking water, basic sanitation, and hygiene and exposure to viruses, bacteria, parasites, and fungi" (Jones, 2006, p.259). Hispanic individuals do not commonly experience these environmental threats before they migrate to the U.S, especially when work conditions and policies differ from the U.S.

Additionally, Hispanic workers are more likely to "interact with psychosocial stressors [e.g., housing and food insecurity, family separation, discrimination, lack of social support (100, 147)]" (Jones, 2006, p.259) than the general population. Being exposed to a variety of stressors over a long period may increase the chances of chronic illnesses that many Hispanic individuals cannot afford to pay for. Hispanics may then only seek medical help once a condition or disease has worsened beyond non-invasive and affordable treatment (Ayón et al., 2020). Federal regulations have been implemented throughout the years to protect farmworkers' health and safety better. However, this has been far from sufficient as agriculture companies have continued to exploit Hispanic workers to harsh conditions with low pay, especially those who are undocumented due to fear of getting deported.

Undocumented Hispanics who reside in the United States are not just more likely to experience harsh working conditions but are likely to have less healthcare access than native-born Hispanic individuals. In 2019, it was estimated that "18% of the Latino/Hispanic population are undocumented in the USA" (Cabral & Cuevas, 2020,p. 875), but most likely, this percentage has increased over time (Passel, 2024). Being undocumented in the United States limits a person's ability to find a stable profession and the utilization of the health care system as well. As mentioned, Medicaid has been an essential health insurance program to aid those who cannot afford out-of-pocket medical expenses.

Those who are undocumented are not eligible for Medicaid, and as a result, many Hispanic families, even those who are documented, are less likely to visit primary care physicians because the adult relatives who are undocumented "have minimal experience with the health care system, preventing their children from receiving timely care" (Cabral & Cuevas, 2020, p. 875). As a result, both older and younger generations of Hispanics are more likely to be uninsured and have difficulty accessing affordable health care in the U.S. when they need it.

Hispanic populations have often shown high life expectancy averages; however, this does not imply they have access to quality health care. According to the World Health Organization (WHO), health is not only defined by the absence of disease but also by the state of individuals' social, mental, and physical well-being (*Constitution of the World Health Organization*, n.d.). In most recent decades, health has been discussed within frameworks regarding quality of life. Quality of life has been prominent for centuries but is often defined as "a generic concept reflecting concern with the modification and enhancement of life attributes, e.g., physical, political, moral, social environment, as well as health and disease."(Daundasekara et al., 2020, p. 268). Given that health should be understood as having access to diverse sources that influence other states of well-being, national and state governments must provide opportunities for individuals to participate actively in their health. However, not all diseases and illnesses can be avoided or cured; therefore, efforts are being made to maximize the quality of life for individuals and decrease impairment.

The U.S. Department of Human Health Services has stated that in the year 2022, “the five leading causes of death among Hispanics/Latinos (of any race) were COVID-19, heart disease, cancer, unintentional injuries, and stroke.” (*Hispanic/Latino Health | Office of Minority Health*, n.d.). Not only are most of these deaths preventable with treatment, but most can be managed for individuals to have a self-sufficient lifestyle. However, many individuals within the Hispanic population, as mentioned, are unable to get preventative treatment or quality-of-life treatment due to language, documentation, and financial barriers. As a result, Hispanic communities are at risk of falling into a pattern where they are unable to access healthcare, leading to a more rapid and severe illness that impairs them from their daily activities, which further limits them from being able to seek out a doctor. As their illness worsens, they often will reach a point where they must seek out emergency services where doctors are unable to effectively treat them unless they can afford very extensive and expensive treatment.

The Hispanic Health “Paradox”

Even though Amanda disclosed that she does not regularly see a doctor, a recent issue forced her to seek help. She told me that she had been excessively bleeding from her uterus for over a month. After her first appointment, she was told that she had fibrosis, in which she needed surgery, but first, she had to get blood work done. She stated,

> Fíjate que cuando yo llegué al doctor de la sangre. Él entró y me miró, y me dijo “¿No sientes que te quieres desmayar? ¿No te sientes mal como débil? ¿No sientes sueño?, no sientes mal? Porque ya traís nomás un punto de sangre.” Pero sabe lo que yo pienso, lo que yo pienso que me ayudó a lo mejor es que vengo de buen cuero porque no. Él me dijo

> "una persona en tu nivel, yo los mando al hospital a que se hagan transfusión y no andan caminando. ¿Y tú por qué?"
>
> Fíjate, yo no sé. Yo pienso que somos de esas gentes de antes, como bien bien duras, que estás mala, pero todavía puedes hacerlo. No sé, te digo, pero yo, yo lo que sí sentía era que me daba mucho sueño, mucho, mucho sueño, pero me dormía y después seguí lavando, limpiando, haciendo de comer todo me iba a trabajar a la oficina y todo.[4]

After interviewing more participants, Amanda's statement regarding being "tough" when it comes to illnesses seemed consistent with other Hispanic individuals' statements. Many commented how often, when faced with symptoms ranging from headache to bodily pain, they usually rely on organic herbs or other health practices to help alleviate discomfort and pain rather than taking pharmaceutical drugs to carry on with their daily work. Thinking through this sense of being tough in the face of health issues motivated me to analyze what is considered the Hispanic health paradox.

The Hispanic health paradox, also known as an "epidemiological paradox," has been a phenomenon that has persisted for possibly over a hundred years but has stumped medical researchers and authors on why this paradox occurs in the United States. The Journal article "*Unraveling the Hispanic Health Paradox"* uses one of the first seminal papers that demonstrated this paradox, written in 1980 by Kyriakos S. Marked and Helen P. Hazuda. They discovered that "Mexican Americans in southwest Texas had a lower infant mortality rate

---

[4] You know what when I went to the blood doctor. He came in, looked at me, and said, "Don't you feel like you want to faint? You don't feel bad, like weak? you don't feel sleepy? you don't feel bad because you already have just one point of blood." But you know what I think? What I think probably helped me is that I come from good skin because, no, he told me, "A person at your level, I send them to the hospital to get a transfusion, and they don't walk around. And why are you?"
Look, I don't know. I think we are one of those people from before, like really, really tough, when you're ill, but you can still do it. I don't know, I'm telling you, but what I did feel was that I was getting very, very sleepy, but I fell asleep, and then I continued working, cleaning, making food, going to work in the office, and everything.

relative to other groups, including non-Hispanic Whites.” and found the same “ phenomenon for life expectancy, mortality, disease-related health outcomes, and mental and functional health” (Fernandez et al., 2023 p. 146). What made these findings confusing for most researchers was that the Hispanic population has comparatively strong health outcomes despite facing large degrees of discrimination and prejudice within the United States, as these factors have negative impacts on health. As mentioned, most Hispanic immigrants and their native-born families are often unable to afford health insurance or be financially stable to seek medical care properly. So, researchers are led to ask: how is it that despite such hardships, Hispanic individuals can have better health outcomes in key indicators like life expectancy and infant and maternal mortality?

This particular health phenomenon within immigrant Hispanic communities is often referred to as having a “health advantage” compared to their non-Hispanic white counterparts. However, characterizing Hispanics as having a health advantage can be misleading as it implies that certain groups are healthier than others. Within health and genetic research, genomics, “Many scientists believe that an understanding of the unique patterns of genes across patient populations defined by race will help identify populations at risk of developing particular diseases.” (Fine et al., 2005, p.2125). Despite the benefits of being able to detect and possibly prevent the development of diseases, it has created the belief that some groups of people are genetically disadvantaged without considering other factors that influence health. Health is not stagnant nor predetermined by our genes. Instead, it is highly influenced by internal and external factors. Even Hispanic migrants who seem to have “better health” have experienced a reduction over the years in their residence in the United States.

This “phenomenon” involves studies reporting that this advantage, “however, erodes as immigrants' tenure of U.S. residence increases […] Scholars documented this phenomenon, called the "healthy immigrant effect," for a diverse set of health indicators.” (Hamilton et al., 2015 p.460). This “paradox” has challenged the actual impact and efficiency of the U.S. healthcare system. This is due to the underlying assumptions that medical researchers have regarding how Hispanic populations should have worse health and the U.S.'s exceptional capacity to provide equitable healthcare. The reliance on these beliefs and assumptions has questioned whether this phenomenon that has baffled researchers ever existed.

Further investigation has demonstrated that these apparent paradoxes are only understood within the flawed framework in which they are studied. The framework of individual responsibility has been a limiting and narrow way to understand Hispanics' engagement with health. A paradox is considered to be “a situation or statement that seems impossible or is difficult to understand because it contains two opposite facts or characteristics” (*Paradox*, 2025). The supposed “facts” that research bases its investigation on the Hispanic health paradox is that Hispanic individuals are more likely at risk of developing illness and disease due to controlled factors like environmental hazards and behavioral factors. The opposite fact that is seen as impossible is that Hispanic communities often have better health indicators than native-born citizens and the rest of the general population. However, a broader examination of complex settings and influences beyond our biological understanding of the body and our emphasis of individual responsibility within the healthcare system makes it clear that the “paradox” can only exist within its limited framework.

Arthur Kleinman has explored the narratives of illness and has concluded that the experience of illness is always shaped by the culture in which “the body-self is not a secularized private domain of the individual person but an organic part of a sacred, socio-centric world, a communication system involving exchanges with others” (Kleinman, 1988, p.11). Many scholars have attempted to understand this "paradox" by focusing on the biological component of the body while controlling for external factors. To assume that the U.S efficiently distributes equitable care is to shift responsibility of the population's health towards the individuals rather than the healthcare system. As studies increasingly directed their attention to interconnectedness in health, a prominent theory has emerged in understanding the "epidemiological paradox" involving social determinants' influence on health over time in Hispanic communities.

Studies have shown that "socioeconomic disparities are key drivers of subpopulation differences in health. Lower socioeconomic status (SES) individuals have a higher risk of disease, death, and disability across the life course than their higher SES counterparts."(Boen & Hummer, 2019, p. 436). Higher SES people, despite being in the same subgroup, have better health than their lower SES counterparts due to numerous social factors that have shaped their health outcomes, including "improved access to healthy foods and safe living environments; better health care; lower exposure to violence; and greater access to health-enhancing social networks" (Boen & Hummer, 2019, p. 436). Social networks have primarily been investigated for their influence on the Hispanic community's reduction of health advantages. A social network is a broad term characterized as "the web of social relations around an individual, including, most importantly, who the contacts are and the nature of the ties that connect" (Smith & Christakis, 2008, p. 407). Social network studies have suggested that "social integration has health benefits. More diverse networks are also associated with better prognoses among those facing chronic, life-threatening illness" (Cohen & Janicki-Deverts, 2009, p. 375). Those who are within a higher socioeconomic bracket are more likely to experience better health due to their access to spaces and resources compared to those with lower socioeconomic brackets. For Hispanics, obtaining these diverse social networks is even more challenging, not only due to structural and economic factors but also through complex dynamics between the broad societal attitudes, polices, and individuals. Oftentimes, these dynamics are shaped through political and systemic factors that can further isolate and deny Hispanics' social integration within the country.

CHAPTER FOUR

CRITICAL PERSPECTIVES

Social Networks and Health

During the final part of the interview with Amanda, she told me that she works at a firm that helps undocumented individuals with work, residency, and citizenship. She proceeded to tell me about a particular client who had migrated to the country alone, commenting:

> "Te imaginas una persona que de veras no habla inglés, una persona que recién llega al país, digamos porque ya ahorita hay personas hasta de etnias indígenas que no saben y llegan y tengo una clienta que ella fue. Y ella es de Guatemala. Ella cuando llegó aquí casi no hablaba ni el español, sí. ¿Y ella…qué sería? Como los 3 meses. Ella se puso muy mala, se enfermó mucho y fue al hospital y dice que nadie le entendía y que duró bien, harto sentada porque nadie le entendía hasta que se desmayó. Y cuando la pasaron. Ajá, le checaron sangre, le checaron todo, tenía diabetes, se le había subido mucho el diabético, nadie la atendía rápido, nadie no le entendía, la mandaban a sentarse hasta que llegara un traductor, pero como va a llegar un traductor, un dialecto, entonces ya ahorita ya habla el español, pero te imaginas o sea lo que le pasa a uno, que gracias a Dios uno pues puede defenderse y más, pero personas así vulnerables…"[5]

A possible explanation for why strong social networks are essential to health may be rooted in human biology. Predominant studies have proven through scientific research that having multiple social relations—whether friendships, partnerships, family, or acquaintances—

---

[5] Can you imagine a person who really does not speak English, a person who has just arrived in the country, let's say because right now there are people, even from indigenous ethnic groups, who do not know how to arrive, and I have a client who was, and she is from Guatemala. When she arrived here, she could hardly speak Spanish. And she...? Like 3 months. She got sick, she got very sick and went to the hospital, and she says that no one understood her and that it lasted a long time sitting down because no one understood her until she fainted. And when they emitted her. Aha, they checked her blood, they checked everything, she had diabetes, her diabetic condition had increased a lot, no one attended to her quickly, no one understood her, they told her to sit until a translator arrived, but how is a translator going to arrive, a dialect, so right now she already speaks Spanish, but you can imagine what happens to someone, that thank God one can defend oneself and more, but people like that are vulnerable...

biologically reduces stress on an individual (Hostinar, 2015; DeVries et al., 2003; Achat et al., 1998; Tolsdorf, 1976). Humans are incredibly social creatures, given that our brains have developed to incorporate a reward system where "socially relevant rewards may be represented in neural circuitry overlapping with that for non-social rewards" (Fareri & Delgado, 2014, p.387). In other words, our brain is structured to make us feel rewarded when interacting with friends, family members, or even strangers. Therefore, social relations and networks can influence "our subjective daily experiences" (Fareri & Delgado, 2014). Additionally, the human brain can reduce the production of cortisol, the hormone that induces stress response within the human body. Stress is not innately a negative state of being, but if an individual experiences stress from different sources for a prolonged period, then it can "make individuals more vulnerable for disease states via suppression of the immune system and has many direct pathological effects" (Brosschot et al., 2006, p.119). Unfortunately, not every individual can make these complex social connections, especially if they find themselves socially and physically isolated or, even worse, ostracized by their country.

Hispanic individuals who migrate from their Latin country of origin sometimes struggle to maintain strong social relations. Most immigrants who arrive in the United States have left family members behind in their country of origin—mothers, fathers, sisters, brothers, uncles, aunts, or even children—to pursue better work or educational opportunities. The Pew Research Center found that "about half of Latino adults (48%) see family ties as better in the origin place of their ancestors" (Moslimani, 2022, p.4). This means that Hispanic immigrants must navigate living in the U.S., including seeking healthcare, most often by themselves or with little aid from available family members. It is then expected that Hispanics may struggle to access quality healthcare due to language and economic barriers. As stated previously, stress is often reduced when individuals have social networks like family members. However, those who migrate to the U.S. experience a high amount of stress not only in adapting to a new country but also in lacking cognitive and emotional support from family members, which can intensify their stress responses.

For those who arrive in the United States with friends and family already settled in, "community factors can also reverse that positive relation, such as discrimination and language barriers" (Fernandez et al., 2023, p.158). Language differences not only create more stress in Hispanic immigrants through the struggle to communicate but also serve as indicators/tools for discrimination and prejudice. According to a national survey conducted in 2021, "about one in five Hispanics say they were told to go back to their home country (21%), were criticized for speaking Spanish in public (23%) or were called offensive names (20%)" (Lopez, 2021, p.20). An article in Health Services Research (HSR) found that "Latinos reported experiencing discrimination at significantly higher levels than whites in health care and several other social institutions, including in clinical encounters and avoiding seeking health care due to anticipated discrimination" (Findling et al., 2019, p.1415). The accumulation of language differences, lack of network relations, and constant experience of discrimination results in prolonged chronic stress. Chronic stress not only impairs Hispanic individuals' decisions to seek medical care but may severely debilitate their immune system, leaving them susceptible to illnesses.

Critical Theoretical Frameworks

To understand how such inequalities and biases occur within the medical field, we must understand how social interactions perpetuate and reinforce discrimination. For centuries, race has consistently been used to categorize individuals based on skin color, eye color, hair, and other physical appearances. However, many scientists have argued that the "categorization of different races cannot be verified by biological constructs such as genetic characteristics" (Kubota & Lin, 2009, p. 2). In other words, no significant genetic differences exist between groups of people who look different physiologically. Despite race being scientifically disproven as a biological reality of humankind, judicial, governmental, educational, and health systems have still utilized race and ethnic categories within the United States.

The reason behind the constant use of race and ethnicity categories has been tied to sustaining social order within the United States. W.E.B. Du Bois was a prominent critical scholar in developing "the concept of race, operating as a mechanism of power, structures relations of social domination" (Gooding-Williams, 2024, para. 3), which has been built upon by other disciplines in understanding its relation to race and ethnicity. Additionally, Du Bois's works supported the concept of social ontology, which exists within the study of philosophy and its understanding of the existence and nature of being (Ontology, n.d.). Social ontology is a specific field that posits that "human societies have a logical structure because human attitudes are constitutive of the social reality in question, and those attitudes have propositional contents with logical relations" (Social Ontology, n.d., p. 15). In W.E.B. Du Bois's analysis of race, he argued that "whiteness has historically functioned as a mechanism of power for recruiting white workers to police and reinforce the economic exploitation of black workers" (Gooding-Williams, 2024, para. 36). If human societies' logic and structure are constructed through attitudes, then what is the social reality within the United States that has historically supported white supremacy as a form of power and control over others?

The social reality that results from the constant emphasis on racial and ethnic differences/categories leads to a clear and strong unconscious—and at times conscious—unspoken message that some groups are lesser than others. Power has been a prominent tool to further support this social reality. Power is both visible and invisible due to the different forms of exerting it. Power is often defined as the authority or ability to make decisions that influence events and/or other individuals. When thinking about power, many usually point to positions within the country, such as political leaders or titles, as examples. However, prominent philosopher Michel Foucault has argued that power occurs not only in a top-down model but also in discourses and individual interactions. Foucault believes that "a distinctive feature of modern power (disciplinary control) is its concern with what people have not done (nonobservance), with, that is, a person's failure to reach required standards" (Gutting & Oksala, 2022, para. 31). But for a standard to be set, there must be a system in place that punishes and controls those who cannot reach those standards. This leads Foucault to believe that in a modern disciplinary society, there are "three primary techniques of control: hierarchical observation, normalizing judgment and examination" (Gutting & Oksala, 2022, para. 33). Individuals do not necessarily need to face judicial punishment to know they do not meet societal standards. Instead, an individual can be consciously and unconsciously aware that observation, judgment, and examination are taking place by other people daily; they or others do not fit within the system that caters to a particular group. Therefore, for this social belief that certain groups are lesser or more than others to exist, it must constantly be present and reinforced through the use of power, not just in authoritarian positions but through repeated interactions that punish and reward individuals according to racial categories. The punishment that minorities then face is both discrete and indiscrete discrimination and racism within society.

Colorblindness Ideologies

Despite critical analysis of race in recent decades, discrimination, racism, injustices, and biases continue to persist. Racism has been observed and understood differently by people who are categorized as white, as most believe that "racism is prejudice, whereas, for Blacks and other racial and ethnic minorities, racism is not mere prejudice but, above all, institutional practices and mechanisms that form a system of racial domination" (Neville, 2016, p. 26). In other words, the perpetuation of discrimination, racism, stereotypes, and biases is integrated at both macro and micro social levels in the United States. In his book called *The Dusk of Dawn*, W.E.B. Du Bois states that "the present attitude and action of the white world...is a matter of conditioned reflexes; of long followed habits, customs and folkways; of subconscious trains of reasoning and unconscious nervous reflexes" (Du Bois, 1940, as cited in Gooding-Williams, 2024). This suggests that individuals participate in daily activities that maintain the social order of whiteness as the predominant way of living while simultaneously preventing other groups of people who don't fit within the "white world" from accessing certain privileges and rights. Despite having knowledge and understanding of how race, ethnicity, and structural racism exist within the country, individuals can still unconsciously support a system that has produced a hostile or inaccessible environment for people who do not fit within the white category.

In recent years, there has been discussion regarding the role of institutions and individuals in perpetuating racism and discrimination within the country. Colorblindness is a concept that has emerged within the discourse on racism. Colorblindness has been seen as a "virtue of character when it comes to perceiving racial differences" (Neville, 2016, p. 39), wherein a person is thought to be relieved of any responsibility in the constant production and enforcement of racism and discrimination within society. Yet many scholars have argued against adopting this mindset due to its problematic approach to perceiving racial differences. According to Helen A. Neville, author of *The Myth of Racial Color Blindness*, colorblindness encompasses four beliefs:

> "(a) skin color is superficial and irrelevant to the quality of a person's character, ability, or worthiness; (b) in a merit-based society, skin color is irrelevant to merit judgments and calculations of fairness; (c) a corollary of (b)—judgments of merit and fairness are flawed if race is included in their calculation; and (d) ignoring skin color when interacting with people is the best way to avoid racial discrimination" (p. 40)

All four beliefs contribute to the notion that if an individual does not engage with race or ethnic identity, then there is no room for discrimination and racism to occur. However, this conception has been argued to be ineffective and contributes to the reinforcement of racism in the country. Colorblindness, despite its intention to dispel racism, "can also justify current inequality. When threatened, White Americans high in social dominance orientation (i.e., preference for group-based hierarchy) use color blindness to defend the status quo" (Plaut et al., 2018, para. 3). The status quo reinforces social order that sustains white supremacy and the systems that exist within it. Additionally, colorblindness can lead to the denial and negation of discrimination and racism occurring and affecting individuals.

Colorblindness cannot effectively exist as a solution to racial discrimination and injustices. Instead, it can be a powerful tool that further instills inequality and distrust between groups. A study found that "Black professionals exposed to a color-blind message and low racial diversity in an organization's brochure expressed more distrust of the organization" (Plaut et al., 2018, para. 8). This distrust stems from the frustration with organizations and individuals who are unwilling to recognize people's struggles, obstacles, and lack of access to resources due to their racial and ethnic categories. Furthermore, removing racial and ethnic identity from interactions between different groups willfully ignores the struggles, activism, and rights that individuals have fought for. While racial differences may not be a biological reality within the human species, they are prominent social realities that have been constructed and reinforced through discrete uses of power, systemic discrimination, and daily interactions. Racism has been and can be perpetuated through the deflection of its existence and its influence on the lives of those who do not fall under what is considered the "norm"—the white category. In recent years, education systems have incorporated different methods to reduce discrimination and racism in fields of study like medicine.

Competency within Doctor and Patient Interactions

One of the first doctors I interviewed was Dr. Jones, who specializes in breast cancer and other malignant cancers in Atlanta. Her work consists of initial consultation, treatment, and follow-ups. She has experience treating individuals who identify as Hispanic, often in her daily conversations. When discussing what makes a trustful doctor and patient relationship, Dr. Jones noted that oftentimes, when needing an interpreter, the consultations take twice as long because,

> You say something that is interpreted into Spanish or whichever language the person is in, and the patient replies. And that has to be translated again so it doesn't leave much time, but I think what we try to look for other than the fact that just being kind, you know, trying to be very respectful and kind and mindful of their culture, whatever constraints they may have, is to build that provider, patient trust, and relationship.

There has been an increase in efforts to understand and be mindful of cultural differences in healthcare, given that institutions in the United States have also been a source and facilitation of systemic racism in the country. Systemic racism is regarded as a theory of oppression where “we all participate in the reproduction of the racialized order. Furthermore, this reproduction depends fundamentally on behavior and actions that are normative, habituated, and often unconscious." (Bonilla-Silva, 2021, p. 513). Systemic racism can, at times, be pinpointed easily if a person were to verbally and/or physically display discriminatory or biased behavior based on race or ethnic identity. However, identifying only the most visible acts of racism and discrimination "makes us pay insufficient attention to the centrality of subtle racial behavior and actions." (Bonilla-Silva, 2021, p. 515). Subtle behaviors have often been integrated into the structure as normative, while "mechanisms, practices, and habituated behaviors lead to actions and inactions from actors that reproduce privilege for some and disadvantage for others." (Bonilla-Silva, 2021, p. 516). Unfortunately, the subtle integration of systemic racism has inhabited the U.S. healthcare system, leading to life-threatening effects.

In the healthcare industry, there has been extensive research on health disparity, but it "typically focuses on health problems faced by people of color and neglects the white perpetrators of racist practices and institutions creating these problems." (Feagin & Bennefield, 2014, p.8). The healthcare system in the United States has historically been constructed to cater to the white population. Reform in the past decade has eliminated visible factors contributing to care inequality between groups of people. Healthcare education systems have also been persistently incorporating the idea and practice of competency in caregiver and patient settings. The National Institutes of Health (NIH) defines competency as " the knowledge, skills, abilities, and behaviors that contribute to individual and organizational performance."(*What Are Competencies?*, 2017). Cultural competency has been a recurring form of healthcare competency, especially concerning migrant groups in the country.

Cultural competency involves the "discussion of practical issues that medical professionals encounter. Including knowledge about people's social values and how people discuss issues in colloquial or regional ways, such as regionalisms and colloquialisms" (Magaña, 2019, p. 2193). Cultural competency has been emphasized in the education of medicine because data demonstrate that migrant groups like Hispanics "avoid seeking care because they have concerns about cultural misunderstandings and confronting racism" (Magaña, 2019, p. 2192). Misunderstandings can occur between doctors/caregivers and Hispanic patients because of language differences. Language is crucial for communication directly and indirectly through the utilization of metaphors that contain different conceptions of illness and health within the context of the culture.

An example of the importance of language and cultural context is a study that was conducted that demonstrated that mental health is discussed as a passive subject in the Hispanic native language. Researchers observed the frequent use of metaphors: "Personifying abstract concepts helps people understand them better because it allows people to make sense of a phenomenon in terms of something familiar to us" (Magaña, 2019, p. 2196). However, when the statements of Hispanic patients were translated into English, it was challenging for doctors who did not know the cultural concepts being communicated to understand the symptoms that the patients were experiencing. The struggle to properly digest and accurately treat patients who come from different cultural and language backgrounds can then lead to miscommunication of treatment, understanding, and distrust between patients and caregivers. Therefore, cultural competence seems to be "an analytic distinction between race and ethnicity acknowledging distinction between edges that 'perceptions of racial difference form one of the most fundamental divides in social life' (5) and thus calls attention to the unique challenges, wrought by deeply entrenched discrimination" (Carpenter-Song et al., 2007, p. 1362).

Many medical providers and medical education institutions have directed their efforts to implement cultural, communication, and language competency. However, authors Joe Feagin and Zinobia Bennefield state that despite such reform taking place, “ significant data strongly suggest the majority of white health care and public health personnel, and researchers operate from this white framing, with its pro-white and anti-racial-others orientations.” (Feagin & Bennefield, 2014, p.8). The framing within which health personnel and research seem to work is based on normalizing biological and cultural differences between racial and ethnic groups. Reforms like cultural competency can sometimes create “Oversimplifications of the concept of culture may conflate culture with race or ethnicity. Notions of culture on race and assertions of fundamental differences among ethnic groups are often the basis for cultural competence efforts” (Carpenter-Song et al., 2007, p. 1363). Emphasizing the different groups can then allow organizations and individuals to look past the similarities that other groups also have, perpetuating the division between those who fit within the “white world” and those who don’t.

Anthropological studies have demonstrated that the competence models that are taught and implemented “present culture as static; treat culture as a variable; conflate culture with race and ethnicity; do not acknowledge diversity within groups; may inadvertently place blame on a patient’s culture;” (Carpenter-Song et al., 2007, p. 1363). Ultimately, even incorporating cultural competence has limitations due to the possibility of failing to deliver quality care to a patient. When failure to provide the ideal care that competence promises, the only explanation is due to cultural differences. That is to say that a person's beliefs, language, and customs are looked down upon as the problem for their health status and care, instead of taking accountability as a caregiver to navigate obstacles and setbacks efficiently and effectively for a patient to receive quality care.

Linguistic Inequality: Medical Terminologies and Health Data Collection

Yasmine has lived their entire life in the United States and is currently in their early forties. Yasmine has worked as a nurse for a cancer clinic for more than 8 years, and while she identifies as Hispanic, she understands little to no Spanish compared to her husband, Carlos. Carlos was born and raised in the United States and can communicate effectively in Spanish and English. At the beginning of our interview, Carlos said that without his wife, he would have been less inclined to see a doctor regularly as he does now. He disclosed an instance where he had switched jobs recently and, therefore, had adjusted his insurance plan. He had been taking a particular medication before, but after his employment switch, the insurance had refused to pay for the medication they had previously covered. He then explained that the situation was handled by his wife, to which she responded:

> No, seriously. Had he not been married to me, he would not have gotten what he needed because he was like, "Oh, well, the insurance is not paying for it." So, I was like, "But why?" he was like," I don't know. They denied it." So, I called the insurance. Why did you deny this? For example, one of the things was, "We only allow you to have one pill per day for 30 days." and the medication that he got, he needed a pill and a half.
>
> Yeah, and I was calling his doctor and his insurance. I called several pharmacies, and most people just said, "Okay," and they didn't get what they needed. Carlos would have said, "Okay." I'm the one who said, but why? The only reason I know that is because I'm a nurse.

Carlos, who is fluent in Spanish and English, has difficulty navigating the different aspects of health care, like the clinic, pharmacy, or insurance. How might people who migrate to the U.S. with little to no knowledge of the English language be able to navigate its health care?

As previously mentioned, language is crucial not only to communicate and understand individuals but also to take in new information properly and adequately practice the latest skills or knowledge. However, languages like English have their own styles. When navigating the

United States healthcare system, the language primarily used is English, but the style is often scientific. Medical terminology has its concepts, words, and phrases separate from average English literacy, which is tricky for fluent English speakers. In 1991, the American National Standard Institute (ANSI) organized the development of standards for healthcare information in the U.S. so that it could participate effectively in global health efforts (Chute et al., 1998). The result was that“[t]he joint Working Group on Codes and Structures of the CPRI and the Vocabulary Working Group of the ANSI Health Informatics Standards Board have developed this framework for the development and evolution of health terminologies.”(Chute et al., 1998, p. 505). Medical terminology is then developed not just as an English style but as its universal language, where physicians, nurses, and scientists can effectively communicate about conditions and treatments for patients. However, with new technological developments, medical terminologies need to change constantly, but with such rapid change, there is bound to be miscommunication and errors in the understanding and implementation of medical knowledge toward patients.

The advancement of technology has made information more manageable and more efficient to access. Still, with vast amounts of data collected, retrieving and reviewing specific details properly takes longer. In 2010, the Department of Health and Human Services (DHHS) implemented new rules and regulations requiring all healthcare providers “all U.S. healthcare providers and institutions participating in Medicare and Medicaid programs to implement an electronic health record system by 2015.”(Awaysheh et al., 2018, p. 17). With most medical organizations being required to utilize electronic platforms to “promote the ‘meaningful use’ of health information technology by the DHHS, the volume of health information recorded in the organizations’ repositories will grow exponentially” (Awaysheh et al., 2018, p. 17). The policies that the DHHS implemented applied to every Hospital, clinic, and lab within the United States but were not specific about which platform all data should be collected and stored on. Without a universal electronic system to store all medical records, medical organizations have utilized different electronic systems with guidelines on what medical terminologies are used, documented, and analyzed in digital form. Not having consistent electronic systems to collect patient health information can lead to time-consuming restraints for patients to receive the necessary care.

Linguistic inequality: Patient comprehension and Navigation of the Health System

It can be expected that a patient is likely to seek medical care from various locations due to personal preference, convenience, or emergency events. Before technological advances took place, providers had to rely “ on faxing or mailing each other pertinent information, which makes it difficult to access in “real-time” when and where it is needed”(*Benefits and Drawbacks of Electronic Health Record Systems*, n.d, p.48). It is expected that electronic health record (EHR) systems that electronically store medical records will no longer be the issue of transferring data. However, as mentioned, there is no universal EHR system in the United States, resulting in a continuous delay in information transfer given the different EHR systems utilized by medical organizations and the required consent of recipients for their data to be accessed. Patients must then take on the role of mediator between health providers to properly get the treatment they need. Therefore, patients must navigate a system that seems to have different ways of handling medical information while having its universal language that is highly complicated if you are not a medical provider and constantly changes with a system that keeps evolving.

Studies have demonstrated that more than half of the American population have received at least a high school education, but “studies have indicated that reading ability is often not consistent with education level, and is often several grades lower" (Sand-Jecklin, 2007, p. 120). Therefore, average Americans are likely to not effectively understand certain medical information provided to them verbally or visually. If a patient cannot follow instructions or comprehend the procedure they will undergo, then fatal consequences can occur. Patients may be unable to properly report their symptoms, illness, or diagnoses to other providers if they seek care elsewhere while waiting for their medical information to transfer. For many individuals, time is crucial not just for their health but for their daily activities, like their jobs, caring for family, and being unable to understand medical terminology and information can lead to further delay and miscommunication in receiving quality care. An ethnographic study demonstrated that most patients who must constantly engage with the health system often "experienced treatment burdens that unfolded in three domains within and between everyday life and treatment regimes in the health care system: family and social life; work-life; agendas and set goals in appointments with health professionals"(*Multi-Morbidity*, n.d., 2017, p. 274). The treatment burdens involve individuals prioritizing one aspect of their life over having to find and go through treatment. Many believe healthcare providers "play a key role in educating patients and the public about health-related issues" (Sand-Jecklin, 2007, p. 120). However, with clinics and hospitals understaffed or trying to keep up with an increasing number of patients a day, providers may not have the appropriate time to assess a patient's understanding of the information provided to them appropriately.

It is increasingly difficult for individuals who do not speak fluent English and also not understand the context behind the medical information provided. Most "medical terms are designed to be precise to avoid ambiguity and misunderstandings. This makes the terms very technical, vast, and challenging to grasp for those not well versed." (Warrier et al., 2023, p. 1).

Unfortunately, few resources have been available in the United States to help individuals navigate the healthcare system. Those who find aid still face literacy barriers in understanding parts of the system and adequately describing their conditions and problems to providers using medical terms. There have been attempts to identify and implement new forms for better patient communication and comprehension, like lowering literacy levels on medical pamphlets. Still, for new methods to be effective, the healthcare system must have more consistency of resources and platforms throughout the country for effective outcomes.

The Hispanic community, as discussed, has oftentimes must navigate through health issues with multiple barriers, whether that be linguistic, financial, or legal. In response to the growing number of Hispanic population across the country, there has been a significant push for more healthcare institutions to accommodate such a diverse population. These accommodations have taken the form of physicians being more aware and educated regarding cultural practices and differences through teaching and implementing competence in health consultations. It is, in fact, important to acknowledge differences in values and practices; the heavy reliance on cultural competence may then overlook systemic and perpetuate biases that have been interwoven in macro and micro-interactions within healthcare, including doctor and patient interactions. Delving into the physicians' roles and perceptions of themselves has shown that they can also play a role in reinforcing these systemic inequalities through the use of an individualistic framework

CHAPTER FIVE

DOCTORS' PERSPECTIVES

This chapter explores how the limited framework used by scientists and medical experts to understand the Hispanic Health Paradox can be examined through physicians' perspectives on Hispanic health disparities in the United States and their interactions with Hispanic patients. I note that some physicians in this study have extensive experience providing healthcare to Hispanic patients with limited English proficiency due to their specialized practice.

In my interviews with physicians, I received varied responses regarding their knowledge and opinions on healthcare access within the Hispanic community. Physicians were asked about how efficiency and quality of care are influenced when using interpreters or other language resources to communicate with non-English speaking Hispanic patients. Many reported that consultations with non-English speaking patients had little to no influence on their quality of care. However, the majority acknowledged room for improvement in the translation/interpreting services provided in their clinics or hospitals.

Dr. Jones, who specializes in treating patients with various cancers, stated in our interview that regarding interpreters for Spanish-speaking patients:

> They are adequate, but they definitely leave me wishing that I knew Spanish myself because it's true of any language. However, Spanish is the most common language, and it takes a lot of time. For me to get my thoughts across for the interpreter to then convey that in a way. So, every meeting and every conversation takes at least twice as long. Yeah, sometimes I wonder if they are translating correctly, I mean, all the nuances, and

> sometimes we have patients that come with a relative, and often they will indicate that the interpreter did not do an exact job.

Multiple physician participants expressed similar encounters with patients and described time management issues when using language interpreters and/or other translation resources. Additionally, depending on the focus of their medical practice, some physicians have more difficulty accommodating patients with equal and adequate time. For example, Dr. Abraham, who works as an emergency physician, often cares for 20-30 patients daily, compared to Dr. Jones, who sees only around 10 patients daily. Dr. Abraham expressed that due to working within emergency medicine, he does not usually see the same patients regularly. This makes it more challenging to establish trust with patients, given that, most times, many patients are admitted and discharged in the emergency room. Patients often experience long wait times of 3-4 hours or more to be seen by emergency physicians. Dr. Abraham discussed and explained to me how wait times have been a constant problem in his field of practice, describing it as a pipeline issue.

> That's like patients are flowing, right? We're supposed to be a pipe. And then, we direct people to the pipe that directs people to other places—the problem with the pipe and why it's bursting. And I, this may not be an analogy that they use. They use some other analogy. But it's three factors. So either the pipe is too small, or there's too much water trying to flow through the pipe. Water has nowhere to go after. The main issue is not the pipe, the size of the pipe, or the resources of the pipe most of the time. The problem is that the water has nowhere to go. So, we don't have enough inpatient beds. So, up to a 3rd or 40% of the rooms in the ER are occupied by people who should have been admitted to the rest of the hospital. So that means that a lot of our nurses, a lot of our X-ray machines, a lot of the resources that we have are not going to the ER patients that need to be seen, but the patients that should have been admitted and should have been somewhere else.
>
> The reason why those patients are not going upstairs is because inpatient beds are not profitable for the hospital, for any hospital in our healthcare market. So hospitals keep

> investing in surgical beds and cancer centers and procedures that bring a lot of money to the hospital. But actually, the number of inpatient medical beds keeps shrinking. So yeah, patients have nowhere to go. And so there's no primary care. So we have more patients coming in. So When people think about wait times in the ER, they want to make the ER bigger, and they do, and it helps a little bit, but it only helps temporarily because what we really need is fewer people coming in and more places to send people.

Through Dr. Aberham's understanding of patient flow, most E.R. physicians must learn and work with the flow of patients coming in and out from the different parts of the hospital while also effectively providing appropriate and quality care. E. R. physicians like Dr. Aberham noted that despite obstacles in forming efficient and effective trust with patients in a short amount of time, they make sure that, communications happens:

> I always ask, “Do you prefer English or Espanol?” And so. But I kind of jump point, and then at the end. I will ask them, “Hey, where are you from?” If I feel like they're kind of amenable to it. Some people, you'd like, try to make that connection and be like, “Hey, I'm Hispanic, too. Where are you from?” People are like, “Hey, I was born…. I’m 3rd generation.” Part of it is the kind of setting of the ER.

Based on Dr. Aberham’s statements, it seems that most ER staff must then, at times, allocate their time to as many patients as possible, which leaves little room for more in-depth personal conversations that would create a more comfortable environment for the patient. Through his explanation of the in and outflow of patients in most medical emergency settings, he acknowledges that emergency physicians are limited to what is provided; therefore, they must work within the framework in which the health system prioritizes healthcare that can provide the most profits. Dr. Aberham notes that despite these constraints, he takes the time to make patients feel comfortable by attempting to make a mutual connection with Hispanic patients due to his fluency in Spanish and English and his self-identification as Hispanic. He discussed how, even though he is not a certified Spanish interpreter, he still takes the initiative and speaks to Hispanic patients directly to help them feel more at ease and effectively communicate the care they should receive.

Similarly, Dr. Paten, who also works as an emergency physician, has run into the issue of wait times and a high number of patients coming in. Dr. Paten also identifies as Hispanic and has a wide variety of experience in consulting with Hispanic patients who do and not speak the English language. When he was asked about his ability to balance the demands of many patients while still providing an adequate amount of time for patients to feel heard, he responded,

> Yeah, it's the daily issue of an emergency medicine doctor. Being an emergency medicine doctor is way more complex than knowing how to manage the medical presentations for everything and how to diagnose most things. I think a lot of it is balancing, and it takes years. I won't say I'm nearly close to it being good or perfect, but sometimes you just gotta… you become a master of triaging. Unfortunately, there are plenty of days where I wish I could spend more time listening to my patients, but I need to know if they're sick or they're not. That's something that trumps my intention to be more of a listener, even though I try my real best not to interrupt them when they're talking to me and give them the space to communicate where they can because it's also an important component of healing. That being said, I think there are specialties in medicine overall that are catered more towards fulfilling that aspect of a listener, so I don't think that's a whole that is uncovered.

Both physicians expressed their understanding that emergency healthcare is often not prioritized and, therefore, physicians and other medical staff tend to lack the appropriate resources to treat patients efficiently while also being able to have a mutual conversation with them regarding their health concerns. Through their statements, they demonstrate a belief that the health system underprioritizes some aspects of emergency medicine and lacks resources to aid Hispanic non-English speakers properly. Despite these obstacles, they take it upon themselves to make sure that the patients they receive are comfortable with them while also taking on the roles of interpreters and listeners in their consultation with Hispanic patients. Their statement also demonstrates a broader prioritization and emphasis on individual accountability as physicians in the healthcare system. However, the focus on personal accountability shifts patient care and interpretive responsibility from healthcare systems toward individual physicians. Physicians and other medical staff have been trained to assume responsibility for the patient's care, even though it takes collaboration and multiple forms of expertise to provide equitable and efficient care. In considering individual accountability in their practice, they gradually accept the existing limiting work conditions. Through this gradual acceptance, individual accountability becomes a method to assert control over physicians and Hispanic patients within the U.S. healthcare system.

Control, as previously mentioned, is often achieved using power; however, for both subjects and objects of power, it can be discreetly embedded to remain invisible. Physicians' actions towards accommodating Hispanic patients, such as interpreting, asking personal questions, and listening to their concerns, can be understood as individual responsibility or accommodation acts that seem separate from the healthcare structure. However, despite good intentions, these accommodations work within prominent French philosopher Michel Foucault's theory on biopolitics. According to Foucault, biopolitics is where “For the first time in history . . . biological existence was reflected in political existence. . . . But what might be called a society’s ‘threshold of modernity’ has been reached when the life of the species is wagered on its own political strategies” (Foucault 1980, as cited in Moore et al., 2011, p 34). In *Biopolitics: An Advance Introduction,* Foucault’s theory of biopolitics can be understood in three different ways:

> First, biopolitics stands for a historical rupture in political thinking and practice that is characterized by a re-articulation of sovereign power. Second, Foucault assigns to biopolitical mechanisms a central role in the rise of modern racism. A third meaning of

> the concept refers to a distinctive art of government that historically emerged with liberal forms of social regulation and individual self-governance. (Moore et al., 2011, p 34)

Within these three understandings, biopolitics have ultimately reshaped how power has been used and implemented to regulate different populations. Foucault moved away from the traditional understanding of power, limiting individuals' and groups' freedom through rules and laws, but rather understood it as more active and discrete. Foucault argues that power in biopolitics is “bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them.” (Foucault 1980, as cited in Moore et al., 2011, p 35). Power, therefore, is not always a form of repression where punishment takes place, but rather, it also operates at the level of constructing social realities, behaviors, and norms. Power being productive in shaping social reality can then operate through institutions and policies that help populations regulate themselves. The healthcare system is firmly situated within these dynamics of producing social realities with its policies regulating medical staff and patients. Therefore, the assumption of individual accountability in physicians' practice, which should require systemic level accountability, is self-regulation within the profession that ultimately influences physicians' labor and thought processes when encountering different populations like Hispanics. As a result, physicians’ self-regulation can influence Hispanic patients' interactions with the U.S. healthcare system.

Spanish-speaking physicians are often expected to provide health consultations and interpreting assistance for non-English-speaking Hispanic patients, which may result in them seeing more patients than they would usually take on or dealing with different types of cases outside of what the physician is specialized in. Dr. Andrade has explained that in her years of practice:

> I don't go up until, like, I think I basically see toddlers. I can start at toddler to almost preteens, like 11-12, where I cap. I'm not a teen specialist, so that's where I kind of say I'm not.
>
> I am more flexible when it's a Hispanic family. A lot of times, aside from the child. Having whatever issues it is, it's usually a result of like—an environmental or family issue. I can help them either navigate the system because I understand the language or the system better, so I can help them that way. Or I can help. I also do a lot of family work because I work with small children. It's something family-related, I'll take the case that way because it's not; it's never usually just a case with the child. Like for instance, I have right now in my case. With an 18-year-old, which I would never take usually. But it was a family dynamic, so the family only spoke Spanish—not the children, but the parents. So, I took on that case, and that's an exception and not really what I usually take.

I could tell that Dr.Andrade was very passionate in not only discussing the issue revolving around Hispanic health disparities, like the level of difficulty it is for people in the Hispanic community to navigate the health system but also being available to Hispanic families to aid in their understanding of mental health and the healthcare system as a whole. However, like other Hispanic physician participants, Dr. Andrade seems to be one of the only ones in her practice who speaks Spanish; this results in her having to allocate her time to aiding in interpretation for other medical staff. Hispanic physicians may also receive cases outside of their regular demographic of patients, which may or may not influence the quality of care they receive despite their willingness and enthusiasm to help.

In the case of Dr. Andrade, she usually treatins patients under 13 years of age; however, she often welcomes Hispanic patients who fall under a different age range despite her specialty being different. Even though her aid can help with family dynamics and understanding of the health issue at hand, there is a possibility that Dr.Andrade may struggle at times to work with the patient, given that her specialty is a different age group. It may take more time and effort for Hispanic patients to progress in their health, but similar issues may arise if they go to a specialist who meets the patient's age range but does not speak Spanish. Hispanic patients are likely to be at a disadvantage in receiving efficient and effective quality care due to the lack of Spanish-speaking specialists and the over-reliance on individual physicians to fill these gaps rather than addressing systemic inequities directly.

In healthcare and medicine, biopolitics have influenced how physicians have internalized systemic norms even through their acknowledgment of Hispanic health disparities. Physicians like Dr. Aberham, Dr. Paten, and Dr. Jones have observed that there are flaws within the healthcare system in the U.S. that create unequal health access for Hispanic communities; however, they, at times, struggle to suggest reforms in the healthcare system to help reduce health disparities or acknowledge their own, or other physicians', influence Hispanics individuals experience and navigation of the healthcare system. This is because physicians are situated within the healthcare structure where individual accountability is often assumed, preventing them from considering the possibility of reforming the healthcare structure from their position as physicians. Self-regulation within physicians through education and emphasis on individual responsibility perpetuate and sustain these health inequalities within Hispanic communities by making health inequities appear to be resource and time-based issues rather than the outcome of institutionalized power structures, allowing the healthcare system to keep sustaining itself in its current form without exercising punishment. Physicians' self-perception of being neutral actors further complicates the ability to recognize how race, ethnic, and health disparities keep persisting, especially in Hispanic populations.

"Neutral" Actors in Medical Practice

Based on physician participants' statements in interviews, I concluded that they often seem to balance between acknowledging certain parts of how ethnic and racial identity may influence patient care, which leads to self-regulation when engaging directly and indirectly with the Hispanic community. In a previous section, I touched upon the concept of colorblindness within the topic of racism and the re-enforcement of it through the belief that “ignoring skin color when interacting with people is the best way to avoid racial discrimination” (Neville 2016, p. 40). However, individuals who adopt colorblindness navigate their daily lives within the frameworks and understanding of race. *The Myth of Racial Colorblindness* demonstrates this dynamic by providing a dialog of a mother who believes that teaching their kids colorblindness is a positive teaching method but later “offered a quasi-cultural explanation of racial group difference and why she would not want to live in a Black neighborhood.” (Neville 2016, p. 163). Colorblindness may seem to stem from good intentions. However, it ultimately avoids any discussions of the responsibility that an individual has for participating in acts of racism, discrimination, or biases, whether conscious or unconscious, that may then help reinforce it. This unconscious---and at times conscious---- reinforcement of racial prejudices and discrimination through the individual belief that race or ethnic identity does not influence one's rights or experiences is striking and similar to what is discussed with physicians and their roles within the healthcare system.

All physician participants acknowledge that Hispanic individuals may have a more challenging time getting the care they need based on language differences, financial barriers, lack of time, etc., which often are associated and are discussed as failures solely belonging to the healthcare system's lack of prioritization of distributing resources that have perpetuated healthcare disparities among the Hispanic community. Despite their ability and willingness to make these critiques, physicians are taught and work within the same system, which has been causing health disparities in the community. Often, physicians do not believe that they or other doctors have a role in this constant reinforcement of biases, discrimination, and health inequality. As seen with Dr. Langford's initial statement, people seem unsatisfied with doctors' “robotic” approaches during consultation because “what's perceived by the patient is like the frustration and impatience of the doctor.” This statement fairly reflects the lack of time available for longer consultations to take place. Still, it also redirects physicians' role in the interaction many Hispanic participants have experienced in the U.S. health system. Similarly, as seen with parents who adopt the teaching of color blindness, physicians may also unconsciously partake in the reinforcement of inequality of access through self-regulating their actions and aid towards the Hispanic community concerning policies and rules set within the healthcare system.

Physicians can sustain health inequality by internalizing *habitus* shaped within the environment and space of the rules and policies they must follow, even if they may not acknowledge that their roles influence individuals' access to health. An example would be when Dr. Aberham states that even though he is not certified to interpret for Hispanic patients, he believes that,

> I'm not just gonna stand there and be like you know I can’t. Ultimately, they're my patient. And if I, you know, they're having a stroke. And I need, you know, a neurologist to help me. We're not, you know, we actually have in-person Spanish interpreters who are great and very accessible. But I'm also, you know, in like the hyperacute life or death thing. I'm not gonna wait around in other situations. I will. It's not so bad if it's not a life-or-death issue. I'm not gonna translate, you know, hey, can you like? Can you help me discharge this patient and like translate? I'm like, no, you have to do it. I'm not.

They take it upon themselves to be available to interpret Spanish-speaking patients during emergencies. However, they often decline to aid in interpretation in non-emergency cases because they have a high caseload, and the hospital already provides two in-person interpreters. Adding non-English speaking Hispanics when not required helps patients get effective and efficient care while promoting patient comfort. Physicians within the hospital or clinic must still follow policies and regulations to avoid complications or conflict with patients. Spanish-speaking physician participants have stated that they are highly discouraged from communicating with Hispanic patients in their native language due to them not being certified to do so. Physicians like Dr. Aberham have, at times, the ability to go against these regulations depending on the necessity of a situation. But, he also disclosed that there was a moment when another medical staff reported him for interpreting for a Spanish-speaking patient without the proper credentials. As a result, he must then be more aware of his decisions and judgment when interpreting Spanish-speaking patients. Having persistently been taught what procedures to take when engaging with non-English speakers and having extensive practices and encounters ultimately leads to physicians developing a habitus.

Prominent French socialist Pierre Bourdieu has explored the theory of habitus and its construction through social conditioning and experiences. Bourdieu states that habitus is a

> system of durable and transposable dispositions which, integrating all past experiences, functions at every moment as a matrix of perceptions, appreciations, and actions, and makes it possible to accomplish infinitely differentiated tasks, thanks to the analogical transfer of schemata acquired in prior practice. (Bourdieu 1972, as cited in Hadas, 2021, p.10)

Habitus is when individuals are within a particular space, constantly absorbing and embodying social exposures with structures, patterns, and experiences. According to *Outlines of a Theory of Plural Habitus,* the “functioning of habitus is often explained by the metaphor of the “sense of the game” that comes into play through spontaneous improvisations during social interactions” (Hadas, 2021, p.10). Understanding habitus as the “sense of the game” means that routines and repeated experiences result in cognitive disposition and a bodily one needed for the practice (Hadas, 2021). Therefore, habitus can be highly influenced by the social conditioning of a particular space that can help guide individuals’ judgments and behavior to a point “without having the time to think" (Hadas, 2021, p.11). Habitus, however, does not totally limit and constrict individuals through these embodiments but is subject to be shaped by social conditions that make it difficult for change to emerge and persist. The medical field is a particular space where habitus can occur. Physicians and medical staff often develop through constant medical teaching, practices, and experience interacting, understanding, caring, and aiding patients. Physicians, therefore, cognitively and bodily express depositions from their training and social expectations that shape how they engage with patients both in and outside consultations.

Physicians can then be the driving force behind whether certain patients, like Hispanic individuals, receive aid. Adding patients can take many forms. It is not inherently tied to a doctor to perform medical help to an individual; it can be an act as simple as giving directions, interpreting, taking them on as a patient, recommending other doctors, etc. Like Dr. Aberham, many physicians sometimes choose whom they can aid or in what way, and those choices are constructed by what they are taught to believe is the best course of action for the patient. Despite making the most reasonable choice in whether to aid a patient or in what form, it can feed into the systemic issues within the healthcare system. For instance, many participant doctors have stated the extra time and effort it takes to have a non-English speaking patient and an interpreter as it involves a lot of back-and-forth communication. Dr. Vega, who is Hispanic and fluent in Spanish, commented on this:

> Providers know where the extra effort, so they just sometimes try to not see this patient whenever possible. I see this very often because many of my colleagues, when they know there is a Spanish-speaking patient, they say, just go and see Doctor____. They will be happier, which may be true, but another reason for that is because they don't want to deal with, you know, translation services are again not compensated, and it will just make it more uncomfortable for both the patient and the provider.

Dr. Andrade, who practices psychiatry, echoes her comment:

> I often help more. I do not have too many colleagues because they won't keep those cases, but I help the front desk a lot because there are a lot of people who are confused. They've come here, know where to go, or people who call. So I get called in a lot.

Dr. Andrade's clinic does have available interpreters for providers, although,

> They still won't take it if there's at least some. Of course, if they have at least some knowledge of the language, and I know for a fact that we have psychiatry residents and fellows who come through the clinic. We have one who has the knowledge, and she feels comfortable speaking Spanish, but not so much the medical terminology. So she'll take cases, but she'll use a translator.

Both doctors have noticed that most non-Spanish-speaking providers sometimes seem reluctant or avoidant to take in non-English Hispanic patients within their respective practices. Training that leads to the understanding that it will be more effective for Hispanic patients to receive care from a Spanish-speaking physician than an English-speaking one. While this assumption may stem from a well-intentioned emphasis on cultural differences that can influence health practices, beliefs, and outcomes, it also unconsciously creates and enforces an atmosphere tied to the U.S. healthcare system, where certain groups of people—non-minorities—can receive more efficient care.

Multiple academic discussions have been held surrounding power and expertise in doctor-patient relationships and international influences on health. Michel Foucault argued in his discussion of the history of sexuality that power and control are “exercised via other people’s knowledge of individuals such as doctors’ knowledge” (Gutting & Oksala, 2022, 3.5 section). To have the knowledge or expertise of a topic is to have the ability to control others' understanding, which is a form of power shown through normative interactions. This form of control is reinforced through habitus, where physicians embody the practice and knowledge they have repeatedly been exposed to from experience within the healthcare system. Dr. Andrade and Dr.

Vega have witnessed this form of embodiment through doctors' assumptions that take place when they choose not to see certain Hispanic patients due to language differences, demonstrating how social condition and structure influence habitus and perpetuate social and health inequalities even without intent. Medicine and science have often been viewed as objective fields of study; however, Charles Briggs dismantles this belief as as he states, "proyectos hegemónicos depende de la comunicabilidad. En tanto procesos sociales, ambas están íntimamente interrelacionadas"[6] (Briggs, 2005, p. 104). In other words, hegemonic understanding within the healthcare system, like doctor and patient relationships and interactions, are subject to social processes that are heavily influenced by social and institutional beliefs of what a doctor should and should not do with adding patients, which is a habitus, is the exertion of power whether it is through action or inaction.

Having individuals being redirected by physicians can demonstrate to Hispanic individuals that due to their ethnic identity or limited English fluency, they make themselves, as patients, undesirable to the healthcare system. Physicians may make this decision with good intentions to make sure that Hispanic patients acquire sufficient care but may inadvertently enforce the feeling of isolation and exclusion. Additionally, those fluent in Spanish and English are often given a disproportionate responsibility to care for Hispanic patients whom a clinic or hospital encounters. This may then result in Hispanic patients being at a disadvantage, which can reinforce the limited understanding of unevenly distributed based on ethnic and language differences. Through embodying patterns of experience and knowledge, physicians are also

---

[6] hegemonic projects depend on communicability. As social processes, both are closely interrelated.

susceptible to enforcing existing biases and limiting their critical understanding of health inequities.

Surface lever explanation

Unfortunately, physicians' actions in adding patience to their health and understanding are limited, and often, their knowledge of how and why health resources don't reach certain groups is shaped by the system that has sustained them. Physicians expressed a wide variety of answers on their opinions and understanding of the cause of why Hispanic individuals have lower rates of healthcare utilization compared to non-Hispanic populations in the United States. Dr. Jones had explicitly been asked their opinion on why some Hispanic individuals decide to receive health care from their country of origin instead of the U.S. Their response was:

> I think the biggest reason probably is financial. That's probably a whole lot cheaper to get the treatment. Expensive treatments or expensive investigations are probably done in the home country rather than here, is my guess. And the other thing is if it's. If it's a very involved kind of treatment that's going to need a lot of social support and somebody to take care of them while they're getting the treatment, maybe they have more of the support system back in the home country than here. It's possible that would be my second guess, but it's the first thing that comes to.

Dr. Evan, who specializes in palliative care, responded similarly to their opinion on why some patients come in with preventable diseases or conditions. Her statement was:

> See, in medicine, you know, people with worse outcomes come from underserved populations with fewer resources because they don't have access to, you know, they don't have good access to primary care preventive medicine.
>
> You know, like going to your doctor annually to make sure you are, you know, your cholesterol is good, your sugars are good. You know, you have diabetes. If you're a smoker, screening for like lung cancer screening or other cancers.
>
> So, we really, I think, to prevent these serious, especially chronic illnesses, you know, we need to focus more on prevention, and part of the problem is that people, I believe, from like low lower social economic status, certain minority groups have less access to healthcare and are now the sickest patients that we eat with the worst outcomes, maybe

> because they don't have early access like you're saying to these preventive measures, whereas maybe people that do better are from higher economic, social, economic ranks and have good access and get earlier screening and do better. Or maybe they have the resources to get better. That's part. I think that's part of it.

The statements by Dr. Jones and Dr. Evan demonstrate a set of understanding and knowledge of cultural and socioeconomic differences, which can be categorized as having and utilizing competency. Competency in healthcare has been emphasized due to the belief and understanding "that there exist a variety of cultural factors that influence the dynamics of healthcare." (Beagan, 2018, p. 3). However, this framing that some cultural factors can influence health can situate certain cultural aspects as the sole reasons for inequalities in healthcare. When physicians talk about financial constraints, they discuss cultural factors within the Hispanic community similarly. That is to say, they discuss financial constraints as an inherent part of the cultural characteristics of this particular population. This specific view of cultural factors and differences within health outcomes and engagement speaks loudly to critiques of understanding structural violence.

Structural violence has been used as a conceptual framework to understand the various degrees of suffering. Paul Farmer states, "Such suffering is structured by historically given (and often economically driven) processes and forces that conspire—whether through routine, ritual, or, as is more commonly the case, these hard surfaces—to constrain agency." (Farmer, 2009, p.12). Through ethnographic observation, he understands structural violence as not a random occurrence but a careful construction through political, economic, and health systems that make suffering seem normal or inherent in society. Within the conceptual framework of structural violence, Farmer challenges academic works in their engagement and understanding of structural violence. He notes how academic scholars

> Not yet eroded a tendency, registered in many of the social sciences but perhaps particularly in anthropology, to confuse structural violence with cultural difference. Many are the ethnographies in which poverty and in equality, the end results of a long process of impoverishment, are conflated with 'otherness'. (Farmer, 2009, p.23).

Suffering and inequality, as seen in poverty, are oftentimes labeled as outcomes of cultural differences, especially by people in power, to consciously—and at times unconsciously—avoid recognizing the systemic causes. The misinterpretation of suffering due to cultural differences has been prominent within the education of medicine regarding competency.

Cultural competency models have often been taught to perceive differences and cultural factors as stagnant, "because cultural competence models and their assessment tools have been developed in high-income countries such as the United States and Great Britain, they reflect the worldviews and value systems of these cultures." (Capell J et al., 2007, p.33). The U.S. emphasizes individual responsibility and effort with a capitalistic framework where profits and income are highly emphasized within healthcare access. The focus on affordability within the country is often considered a cultural issue within minority groups. This framework is reflected in how physician participants have demonstrated their competence, where there is a focus on understanding the influence of culture and practices along with economic positions on health. Focusing on cultural differences and financial constraints can redirect attention to systemic issues influencing health, to the groups whose cultures have been emphasized to be the cause of health inequalities experienced.

As mentioned, obtaining health insurance under a plan compatible with their health needs is crucial to receiving affordable and effective care. Financial barriers have been proven to be a concern in healthcare access, but discussing them as if they are an inherent part of the culture and only focusing on their causes can oversimplify the issue of health access inequality in the

Hispanic community. The framing of financial barriers in healthcare as the sole drive for unequal access to health and the assumption that it is an inherited characteristic of certain cultures can ignore more profound systemic inequities and reinforce biases.

Literature discusses surface-level systemic issues like financial barriers and geographic location in the U.S. healthcare system; however, systemic problems are often deeply rooted and reinforced through normative beliefs. The belief that financial constraints are one of the sole drivers of health has been normalized in the health system. Physicians gain knowledge of external factors like cost and their influence on health through their training and experiences, which leads to emphasizing surface-level issues. By attributing health disparities in Hispanic communities solely to cost, physicians may then unconsciously absolve the healthcare system of responsibility by building on a narrative that inequality of health is a result of external factors rather than structural failures. Additionally, cultural differences have also been emphasized in providing care regarding its effects on the Hispanic community's health and equity.

For instance, Dr. Langton, a cardiac anesthesiologist, had a different take on why Hispanic individuals tend to utilize health services less than other minorities and if consumerism could be the influence. Their response was:

> Well, I guess the first question would be, do I think that that's why patients don't use it right? Yeah. So, I don't think the consumerism aspect is part of it. I think the medical system is very complicated, overly complicated. I think, obviously, healthcare costs exist, and they are. Probably you know, getting to a point where it's a little bit out of control, but. I don't know if. Cost. You know, to me, I think cost is low-hanging fruit, right to say, well, things cost so much, and that's why people aren't getting healthcare. I think for some people that's it.
>
> But I do think culturally, sometimes the use of the healthcare system or the reasons one thinks they should use it are very different, right? I think in some cultures, people feel like if you feel fine, you don't need to go to the doctor, right? Like I feel. But if I have an issue, I have a belly ache. I have a headache. Well, then I'm going to the doctor and I

> think that, yeah, preventative care, which is really what we tried to focus on in the US, particularly over the last few years. It's often lost because I think it is very much a Western kind of view of how we should kind of behave. In the medical field, which I agree with, I think you know that prevention is the best thing possible. So you can get into like Obamacare and kind of the pros of that and what else needs to be done because we still have a lot of people that you know have not tapped into Obamacare.

There have been countless studies demonstrating that cultural competency has been an effective form of delivering equal and efficient care to Hispanic individuals and other minorities. However, as mentioned, there have been critiques of the emphasis on competence in healthcare. Cultural competence can be a valuable tool to facilitate better communication between physicians and patients from different backgrounds; however, the reliance and emphasis on competence in the medical world can often dispel the impact that physicians have on doctor-patient relationships. In other words, highlighting cultural differences as another barrier can frame disparities in the Hispanic community as their behavior is the problem and, therefore, the cause of their lack of access to health. Rather than addressing how the U.S. healthcare system has failed to accommodate cultural and linguistic needs while also overlying on individuals to bridge the gap. This framing, in emphasizing cultural differences, can shift the responsibility of health inequality to individual patients and physicians rather than reflecting on whether the healthcare system effectively and adequately supports and engages with different cultural backgrounds, practices, and beliefs.

Dr. Reed, who has had over 30 years of experience as a neurogynecologist, commented similarly:

> I would have to believe that there are a couple of reasons. I think there's a systemic racism or ethnicity-based biases that—reduced access to care for minority populations. I think there is a certain distrust of the medical system culturally by certain races and ethnicities. I think there is some lack of cultural competence of the healthcare delivery

> system in their ability to care for—minority racial and ethnic populations. I think there's a certain level of. Religiosity may reduce the likelihood that certain racial and ethnic populations rely on the medical profession for health and well-being. Those are some of the reasons or top reasons, I believe.

Like many physicians who have been interviewed, Dr. Reed acknowledges systemic distrust and racism in the healthcare system. However, in most interviews, discussing these issues often stops without addressing the role of healthcare providers, not just physicians, which can perpetuate biases and distrust. To only recognize but not meaningfully engage and address the roles of health providers in the healthcare system is to reinforce systemic biases and issues. Dr. Reed points out a "lack of cultural competence" within the system but does not investigate how individual and institutional behaviors contribute to this issue. Dr. Reed also focuses more on the differences in culture, including religion, as factors in low healthcare utilization from minority groups. As mentioned, this focus on cultural differences may unconsciously perpetuate biases and assumptions of patients' health behavior, which can make a patient feel disturbed or unsafe by providers, which can cause them to engage less with the healthcare system in the future.

In *Dusk of Dawn,* Du Bois observes that oppression evolves through three states: “from thinking that racial oppression was caused by ignorance; to thinking that it was caused by ignorance *and* ill-will; to thinking that it was caused by ignorance *and* ill-will *and* a conjunction of economic motives and unconscious, irrational acts and reactions.” (Gooding-Williams, 2024, 4.2.5 section). As discussed previously, oppression and systemic issues are highly integrated into normative behaviors and beliefs where they are reinforced and created even through well-intentioned actions. We see this evolution of oppression and systemic issues through physicians' statements on health inequality within the Hispanic community as they are be taught, believe, and discuss that the lack of competence or ignorance of cultural differences often causes Hispanic health disparities. While also addressing the faults and ill wills of the health system and then talking about the “irrational acts” or economic motives in Hispanics' engagement in healthcare outside of the country. The emphasis on cultural differences being a factor in health can also influence the way Hispanic individuals navigate and engage in health services.

An example of patients engaging less in the U.S. healthcare system is demonstrated through seeking health services in other countries. Dr. Escobar, who has worked in cancer clinics as a palliative care physician, responded to the same question regarding Hispanic individuals seeking medical care outside the country. They stated:

> Medical tourism, so I will say that that's a that's the thing I heard a lot when I was a resident, and people were going for things like Brazilian lifts, they voted the bar, and then they are Mexico to get cheap plastic surgery and then come back after that. I heard that a lot; actually, I don't really hear that with cancer. I think, in general, people are sick, and so, like, when they are sick, they're not like thinking about going to get cheap cancer care. I also think that, in general, the impression that most people have is that, like in the Americas, where you get the. Yes, medical care. And so even if they can get cheap plastic surgery, you're not going to get, like, cheap.

Dr.Escobar had commented how people go to countries like Mexico to get “cheap plastic surgery,” but this often seems to be rarely the case for Hispanic individuals who were interviewed. It is then discussed as more of a choice rather than a systemic failure where the country lacks accessibility to the Hispanic community. Focusing on people receiving care outside the country despite the health risk as a choice rather than a last resort can shift the focus away from the need for structural reforms in the U.S. to prevent individuals from risking their health to get the treatment they need. This perspective can downplay how systemic barriers that are deeply rooted in healthcare have put minorities at risk due to a lack of efforts in systemic reform.

Many physicians like the ones that have been interviewed for this study, have shown a great range of knowledge and understanding of the presence of structural failure in the United Healthcare system. However, providers often work in a specific frame where they perceive their actions as separate from the system, perpetuating health disparities. Many are very passionate about aiding their patients, but unfortunately, they can only do so much with what is available to them, and oftentimes are expected to bridge the gap of lack of resources. When physicians enter the medical field, a space that has created health inequalities, they are constantly exposed to the practice, teaching, and experience of framing external factors like culture and financial constraints that influence health outcomes. They ultimately embody this exposure through their practice, which can reinforce biases and shift focus away from structural issues, and attempt to reform the healthcare system. This makes Hispanic patients reluctant to engage in the health system as a whole. It is, therefore, not enough to acknowledge a systemic problem but to actively dismantle it, not just individually but as a community.

CHAPTER SIX

HISPANICS' POINT OF VIEW

In this chapter, I argue that the "Hispanic Health Paradox" is not a true paradox but rather evidence of the U.S. healthcare system's structural failures in serving Hispanic communities. Through my detailed interviews with Hispanic patients and healthcare providers, I demonstrate how Hispanic individuals' experiences with healthcare are characterized by patient avoidance, biases, and stereotyping in medical settings, impersonal transactional care, and widespread distrust of the system. I show that many Hispanic patients resort to seeking healthcare outside the U.S. not out of preference but necessity, driven by experiences of dismissal, rushed consultations, and discrimination. By contrasting Hispanic patients' accounts with physicians' perspectives, I reveal how the conventional framing of the Hispanic Health Paradox—which attributes health outcomes to individual behaviors or genetic factors—obscures systemic inequalities. I ultimately call for a shift away from frameworks of individual responsibility toward recognition of the structural disadvantages embedded in the profit-driven U.S. healthcare system that perpetuates health disparities for Hispanic communities.

Medical researchers and academic scholars have analyzed the Hispanic Health Paradox to understand how the Hispanic population, specifically immigrants in the United States, has substantial health outcomes as compared to the non-Hispanic population. Many academic articles have discussed this "phenomenon" as Hispanic immigrants having a health advantage (Boen & Hummer, 2019; Camacho-Rivera et al., 2015; Giuntella, 2016; Ruiz et al., 2016). As a complement to their analysis of this “paradox,” researchers have also described an additional “phenomenon” that occurs where immigrants, over time, lose this “health advantage.” As previously mentioned, stating that the “Hispanic health advantages may reflect a constellation of factors, including but not limited to genetic/biological advantages” (Ruiz et al., 2016, p.467) creates a false notion that lower healthcare utilization by the Hispanic community is a choice rather than a structural failure in the U.S. healthcare system.

Academic articles also discuss the “phenomenon” of these positive health outcomes being reduced over time due to behavioral factors. Specifically, articles like *Emerging Hispanic Health Paradoxes* state, “a shifting pattern of health outcomes has been observed during the process of cultural adaptation, as this also involves the adoption of certain unhealthy behaviors with greater duration of residency within the United States” (Castro, 2013, p. 1541). These unhealthy behaviors that are one of the leading causes of the reduction of the ‘health advantage” is often understood as Hispanic individuals partaking in “smoking, alcohol use, physical activity, and diet” (Ruiz et al., 2016, p.464). To suggest that Hispanic individuals actively choose to participate in unhealthy behaviors like smoking or drinking at a disproportional rate not only reinforces biases and stereotypes but also sustains the U.S. healthcare system in its current form. This narrative emphasizes Hispanic individual accountability instead of focusing on how systemic failure has possibly influenced this decrease in health outcomes. To label the Hispanic immigrant population's decline in health outcomes as a paradox is to assume, incorrectly, that the U.S. healthcare system distributes care equally and efficiently. Particularly, this chapter seeks to demonstrate how Hispanic participants' responses and experiences have shattered this false reality and instead reinforced how the Hispanic Health “paradox” does not exist due to the limited and narrow cultural and structural framework used.

Patient Avoidance

Amanda was one of the first people I interviewed, and she struck me as a very passionate person who loved to talk about the complex failures and achievements the U.S. has offered to her and her family for decades. She and her husband, Luis, were born in Mexico, and at a young age, they migrated to the United States. I first wanted to know the frequency with which they both use medical services in the U.S., whether primary care, family medicine, or specialized care. Luis stated that ever since he was young, he has had a kidney problem, in which he has to seek out treatment constantly here in the United States. Amanda, however, had stated:

> Yo casi nunca voy al doctor. Yo iba cuando estaba embarazada y cuando me aliviaba, pero nunca he estado-nunca he ido mucho al doctor ni a checarme mucho. Recientemente el año pasado en agosto del 2023 tuve que ir porque me empezó mucho sangrado vaginal y me descubrieron fibromas y polips y me hicieron una cirugía para removerlo primero. Y no sirvió mucho porque nomas me removieron los pólipos y los fibromas y después como a las…. Como el mes me tenían que hacer otra cirugía para sacarme el útero porque sigue por el mismo problema. Pero me dejaron los ovarios nada más.[7]

I was surprised that, compared to her husband, who seems to regularly go to consultations, Amanda, who has spent most of her life in the United States and can speak the language fluently, would only feel the need to go to the doctor a handful of times. Before I enquired about Amanda's decision to seek health services, I wanted to understand Luis's experience navigating and seeking medical care for his condition. I asked him and Amanda how often they seek annual physical checkups. Amanda responded that she doesn’t, but her husband

---

[7] I almost never go to the doctor. I used to go when I was pregnant and when I gave birth, but I've never been-never gone to the doctor much or gotten checked much. Recently, last year, in August 2023, I had to go because I started bleeding a lot, and they discovered that I had fibroids and polyps, and they did surgery to remove them first. And it didn't help much because they only removed the polyps and fibroids and then like... About a month later they had to do another surgery to remove my uterus because it continued with the same problem. But they only left me with the ovaries.

has, to which Luis responded: "Yo debería pero yo no he ido como hace 10 años. No me gusta porque como voy muy seguido al doctor ya no… ya estoy cansado. Sí debería ir pero ya me cansé"[8]. Since he referred to being tired as a factor in not seeking medical care, I wanted to hear more on how that was influencing his decision not actively to seek out physical checkups, so I asked him to clarify, to which he responded:

> Pues ir a los hospitales a los lugares clínicas y todo esos y no lla me siento muy mal porque- se tardan mucho y yo siempre e sido muy ocupado . Además de eso era muy carro. Después de mi seguranza todavía tenia que pagar seis cientos cada mes.[9]

I further asked him about the consultation he frequently goes to for his kidneys and his relationship with his doctors. He commented that the doctor he has been seeing for around 20-30 years has been great given the years he has known them and has established a strong trust with them. He stated that he often has enough time with them to feel satisfied with the care, and the doctors seem to converse with Luis, like asking him about his family, work, stressors, etc. When I turned to Amanda, she stated that everyone has their own experiences, but hers are widely different. She looked at me with a serious expression and stated:

> Te voy a platicar, influye mucho que tú hables el idioma, una experiencia que yo tuve hace mucho. Años me alivié de Jorge, tuve a mi hijo y mi hijo nació con un testículo acá arriba no bajó el testículo a su lugar. Entonces, cuando él nació, los doctores lo examinaron y todo en ese momento yo no sabía, pero el doctor que vino el pediatra que vino a hablar conmigo. Él vio que yo no hablaba español, inglés y él se fue. Yo pensé que iba a venir con alguien que me explicara, pero no, sí. Solo se fue solo me miró y miro que era no sé hispana. A la mejor, dijo. No me va a entender y él se fue. Yo me vine a dar cuenta de lo que tenía mi niño hasta que fui a la primera consulta con él. Mejor no había

---

[8] I should but I haven't gone in like 10 years. I don't like it because since I go to the doctor very often, I'm no longer… im just tired. Yes I should go but I'm just tired.

[9] Well, going to hospitals, clinics, and all that, and I don't call, I feel really bad because—they take a long time, and I've always been very busy. Besides, I was very expensive. After my insurance, I still had to pay six hundred each month.

> alguien que pudiera traducirme o a la mejor, dijo después la voy a ver y le voy a decir, pero.
>
> ¿Nunca se me olvida que me quedé yo con la duda de pensando qué qué pasó, qué pasó? Sí, porque se me quedó mirando y lo conozco. A lo mejor no fue esa es su intención, pero probablemente no dijo. OK le digo en la primera cita, pero tú sabes, a veces es, te quedas pensando a lo mejor tiene algo, a lo mejor tiene algo. O me quería decir algo. Es mi hijo, nació en el 2000. Entonces ya tiene mucho, pero son cosas que te quedas pensando a veces. Entonces el idioma influye mucho en la hora de comunicarte y creo que es muy importante este que tengan eso en cuenta tanto en los hospitales o en alguna otra agencia, porque podría haber sido otra cosa más grave.[10]

While telling me this personal story, I could see in her voice that she was at a loss for words because she had experienced this. The doctor's actions, whether they were in response to her being Hispanic or not, had caused her to go through a period of stress and anxiety about her son's health. As she stated, this particular event still resonates with her after 20 years because of the possible biased assumption the doctor may have had regarding her ability to communicate effectively. While we can never be sure of the doctor's exact thoughts that made them backtrack in their decision to discuss her son's condition with Amanda, the outcome of this brief non-interaction/avoidance gestures to the role of communication in healthcare. As previously mentioned, Hispanic-identifying physician participants have noticed that for their clinics, there seems to be a constant redirection and avoidance in obtaining Hispanic patients by non-Hispanic

---

[10] I'll tell you, it has a lot to do with whether you speak the language, an experience I had a long time ago. Years ago, when I gave birth to Jorge, I had my son, and my son was born with a testicle up here; the testicle didn't go down to its place. So, when he was born, the doctors examined him and everything I didn't know at that moment, but the doctor who came, the pediatrician who came to talk to me. He saw that I didn't speak English, and he left. I thought he was going to come with someone to explain it to me, but no. He just left, he just looked at me and saw that I was Hispanic. Maybe, he said. She was not going to understand me, and he left. I didn't realize what my child had until I went to the first appointment with him. Maybe there wasn't someone who could translate for me, or maybe, he said later, I'll see her, and I'll tell her, but,
I never forget that I was left with the doubt of thinking what happened, what happened? Yes, because he stared at me and I know him. Maybe that wasn't his intention, but he probably didn't say anything. OK, I tell him on the first date, but you know, sometimes it's like, you're left thinking maybe he has something, maybe he's got something for you. Or he wanted to tell me something. He's my son, he was born in 2000. So he's been around for a while, but these are things that you're left thinking about sometimes. So language has a lot to do with communication and I think it's very important that they take that into account in hospitals or in some other agency, because it could have been something more serious.

physicians. In Amanda's case, she possibly encountered a physician who believed it better to communicate with her later with an interpreter or perhaps refer her to a Hispanic physician in the hospital to communicate with her effectively. However, by leaving Amanda in the room questioning, and without any information on the timeline of communication, the physician left a deep scar on Amanda's perception and experience of healthcare in the US.

Whether Amanda could communicate effectively at the time, the lack of engagement from the doctor had not only embedded within her concerns with her child's well-being but also been one of the reasons why she rarely goes to doctors for checkups. Therefore, even if Amanda's doctor was acting with good intentions, his bias regarding her ability to properly give out and take in information had, unfortunately, impacted the efficiency of Amanda's knowledge of her son's health and impacted her mental stress. This one experience is far from abnormal as a study has shown "only 56 percent of Hispanics were very satisfied with their health care, compared with 65 percent of whites." (Escarce & Kapur, 2006, p.435). For many Hispanic individuals like Amanda, who are unsatisfied with the care and engagement in receiving care, ultimately come to the conclusion that their negative experiences are outcomes of a flawed healthcare system, and they feel little individual agency to obtain better outcomes within that system. Such a line of analysis greatly challenges the problematic and flawed way of understanding negative health outcomes of the Hispanic population within the Hispanic "paradox" as "behavior factors" or a "choice" rather than the outcome of systemic failure. Given Amanda's negative interaction with doctors, ignoring her concerns or not giving enough time to ask questions, she then asks:

> ¿Entonces, de qué sirve que haiga doctores? ¿De qué sirve que haya hospitales? ¿De qué sirve, me entiendes entonces?¿Por qué tanta propaganda para prevenir enfermedades? ¿Por qué hay tanta ah llamada pública a prevenir condiciones médicas? A la mejor, a

> veces hasta drogadicciones a veces tú sabes si cuando llegas a pedir ayuda a una clínica o a un doctor o a lo que sea. ¿Por qué no viniste antes? Porque te tardaste tanto en venir al doctor, son como tus padres. Solamente cuando te se te enojan contigo es porque aquí no, no, entonces algo está mal, muy mal realmente.[11]

Amanda challenges what many medical researchers and physicians have often questioned: “Why did you not come earlier?” towards Hispanic individuals who come through their hospitals and clinics in such a diverse health state, resulting in the unfailing systemic reform needed for individuals like her to want to seek out health services actively. Amanda's experience after giving birth to her son demonstrates a limited and biased cultural framework that took place that influenced her stress and concern towards her son's health, but also ultimately was the catalyst for her avoidance of seeking medical help in the U.S. In contrast to her husband, Luis, despite not having a horrible experience in consultations, he has persistently encountered long wait times that have hindered his daily activities, and he is unable to constantly afford consultations despite having health insurance, which also demonstrates the need for systemic reform to reduce the avoidance of the system itself.

Biases and Stereotypes in Healthcare

A Hispanic patient named Anisia, who is 22 years old, disclosed an uncomfortable consultation experience with her father when visiting a primary doctor. She states that when her father obtained insurance and encountered a doctor when,

---

[11] So what's the point of having doctors? What's the point of having hospitals? What's the point, do you understand me then? Why so much propaganda to prevent diseases? Why is there so much public call to prevent medical conditions? Maybe, sometimes even drug addictions, sometimes you know if when you come to ask for help from a clinic or a doctor or whatever. Why didn't you come earlier? Why did it take you so long to come to the doctor, they are like your parents. Only when they get angry with you is it because not here, no, then something is wrong, very wrong really.

> He was having some issues with his triglycerides, and the doctor was like, oh, just stop drinking. And he was like, I don't. I don't drink, and the doctor was like, “Ohh you. What are you working?” and my dad was like construction. He was like, then stop lying.
>
> Like, what do you mean? “It's just like, just you were just, like, just stop doing it like you don’t have to lie to me. Let's be serious. And you say you have to cut down on tortillas.” my family's Honduran, and we do eat a lot of tortillas in Honduras, but we don't really eat them here. We're just not used to eating them here. We don't make them pretty as often.
>
> And he was like, yeah, just cut down on the tortillas and stop drinking beer, and you'll be fine, but he was like,” I don't even eat tortillas,” so there have been experiences like that. And my dad obviously switched doctors. He was like, you're not even listening.
>
> To me, it turns out my dad had something completely different. He needed a different doctor to get his medication changed, and the other doctor fixed it. But yeah, I think that was a really absurd experience.

This example demonstrates this specific doctor's stereotypical bias in treating Anisia’s father based on his ethnicity. Anisia had stated previously that there were periods of times when her family did not have health insurance, and so for her father to have finally had the financial means to utilize healthcare services, only to be met with a doctor who refuses to look further into his health concerns and instead insist for him to stop partaking in stereotypical habits often attributed to Hispanic communities. This problematic notion of the Hispanic population participating in unhealthy behaviors is also used as a primary reason on why the Hispanic Health Paradox occurs, as health outcomes seem to decrease over time for migrants and therefore dismiss any other possibility for these outcomes. Anisia's father, who does not engage in these stereotypical behaviors, was unable to get the care he needed from this particular doctor because of the emphasis on biased and stereotypical cultural understanding of the Hispanic population. This, of course, makes healthcare challenging to navigate as a minority because of the risk of encountering a doctor who is biased and discriminatory on ethnic or racial identity. However, the time it takes to obtain a doctor who performs a satisfying consultation can also result in delayed care. Unfortunately, Anisia has encountered similar scenarios of not being taken seriously when disclosing symptoms and conditions. Specifically, when asked about what would be her ideal doctor, she responded:

> I really needed someone to see consistently. I had my pediatrician and then an OBGYN that I would visit, but it took me, I think, two or three OBGYNs to get one that I was really comfortable with. I think after asking for, like, oh, do you have any concerns? I think if the person does, if I were to give concerns I want them to follow up and ask are you satisfied with the response? Is this like, how do you feel? Do you feel comfortable leaving the office? Do you feel like I answered all your questions about leaving the office? I think that would be a really good question.

A follow-up question was then asked if she ever felt rushed in previous health consultations, to which she responded:

> Yeah, yeah, I've had a little bit of both. Yeah, I think, like, like I mentioned with the pediatrician, she was very dismissive. It was very much, you know, she'd show up. The appointment was at three, so I wouldn't see her until 4. She was there for 10 minutes, max. And then, you know, move on to the next patient. So, I think there it felt really rushed. But also with the other two or three OU. I felt that's one of the reasons why I left. Because I felt kind of rushed. I feel like they weren't really paying attention to what I was saying. But with that one that I really liked, she took her time, and she made sure that I was satisfied with the visit and the response.

Anisia's father's experience, along with both of their decision to switch physicians due to feeling rushed and dismissed, highlights a brother challenge Hispanic individuals face in the U.S. healthcare system. It demonstrated how Hispanic communities often face difficulty finding a trustworthy physician. If a patient encounters a physician they feel dissatisfied with, they have the right to seek out a different physician and ideally would be able to have equitable access to health services. However, minorities like Hispanics often encounter negative interactions with their chosen physicians due to biases within their other doctor and patient interactions (Hall et al., 2015). The biases don't always present as clearly and verbally as Anisia's father's physicians had demonstrated. Still, it can be inaction and well-intentioned beliefs that can lead to the further installment of biases. As previously discussed, financial constraints are a contributor to health inequalities within the Hispanic community; it is not the only or the most crucial reason why Hispanics are less likely to engage in the healthcare system in the U.S. To have repeated experiences of being dismissed like Anisia or stereotyped like her father can discourage patients from continuing to trust and engage in the healthcare system, and reinforce existing health disparities within the community, resulting in what researchers view as a "paradox". Anisia and her father are far from the only ones who experience some degree of dismissal, discrimination, or profiling from physicians they have encountered here in the U.S. For many participants, their lack of trust in physicians and, in extension, healthcare in the U.S. is not only due to ethnic and racial bias but also through its profit-driven structure and transactional, impersonal nature of medical consultations.

Transactional Healthcare and Distrust

A participant by the name of Samantha disclosed to me that in her first years after immigrating to the United States, she had some health complications after the birth of her first son. She stated:

> Fui muchas veces al doctor por un dolor de estómago que tenía- fui muchas veces con el mismo doctor y solo me recetaba una medicina diferente y me decía que hiciera dieta y dietas. Mas nunca me dijo 'ok si lla es muy-si siempre vienes por el mismo problema voy hacerte un sonograma a ver si es algo más grabe. Y lla si pasaron dos años- si pero no era tan constante el dolor pero a veces iba cada dos meses. Depende porque me daba pastillas

> para el dolor nada mas pastillas-para solucionar el problema según. Pero nunca se me alivio.[12]

Later in the interview, she additionally states:

> Para mi yo trabaje con un doctor de pediatra un doctor personal. Pero ya llegando con un doctor quieres—mas que nada es una persona que realmente que tu puedes confiar y decirle realmente lo que tu sientes y como te sientes. Tener esa confianza obviamente no quiero un doctor serio que namas me pregunta “que le duele? Aquí? Acá?” no. Quiero alguien que se interese por lo que me pasa. Porque aves los doctores “ a ver que tiene? Que le pasa? “ es como si nada mas esta check mark y así y así pero no le dicen “ oh ok pero tienes de malestar el estómago que comio o cree usted que fue la causa de esto?”. ósea quieres alguien que realmente preste atención de lo que dice y que te de la confianza para que tú te abra y decirle lo que te pasa. Porque por eso vas y pagas. Pero personas no quieren ir a pagar porque luego no se entiende y namas le dan cualquier medicamento y no se alivian y entonces no tienen sentido “a que voy al doctor?”.[13]

Similarly, Clara, who has spent over 30 years in the United States, discusses her experience in seeking treatment for pain in her hands:

> Una experiencia que me tocó cuando me atendió una doctora. Y le dije lo que iba, era porque tenía dolor en mis dedos, la punta de los dedos. Y ella solo me me tocó los dedos. Me mandó con el especialista como si yo tuviera una enfermedad crónica que yo no fuera a curar. Cuando voy con el especialista me dice que por qué yo voy para allá, le dije que la doctora me dijo que fuera para allá, me dijo. “No te tenía que haber mandado para acá porque tu no tienes una enfermedad crónica” como me debió de haber atendido. Y qué tan rápido era porque he oído historias de diferentes personas que una a veces entras, te

---

[12] I went to the doctor many times for a stomach ache I had. I went to the same doctor many times and he only prescribed me different medicine and told me to go on a diet and diets. But he never told me, 'Okay, if it's really bad, if you always come for the same problem, I'm going to do an ultrasound to see if it's something more serious.' And then two years went by. Yes, but the pain wasn't that constant, but sometimes I went every two months. It depends, because he gave me pills for the pain, just pills, to solve the problem, depending. But I never got relief.

[13] For me, I worked with a pediatrician, a personal doctor. But when you get to a doctor, you want—more than anything, a person that you can really trust and tell them what you feel and how you feel. Obviously, I don’t want a serious doctor who just asks me “what hurts? Here? Here?” No. I want someone who is interested in what’s happening to me. Why do doctors say “let’s see what you have? What’s wrong?” It’s like there’s nothing more than a check mark and so on and so forth, but they don’t say “oh okay, but do you have an upset stomach? What did you eat? Do you think it was the cause of this?” I mean, you want someone who really pays attention to what you say and who gives you the confidence to open up and tell them what’s happening to you. Because that’s why you go and pay. But people don’t want to go and pay because then they don’t understand and they just give them any medicine and they don’t get better and then it doesn’t make sense “why do I go to the doctor?”.

> ven por 5 minutos o 10 y ni te hablan, así como ni te dan platica y luego te no te hacen algo así, así, fue ella, así me pasó. Que estuviera por esto, que si era por lo otro, y me dijo "¿Tienes artritis? ¿Ve con este especialista que se especializa en la artritis?.". Y él me dijo, "No tienes artritis. Aquí están las fotos de las personas que tienen artritis.".[14]

The different stories that participants tell demonstrate that lack of trust in the healthcare system stems from rushed consultation that leaves Hispanic individuals unsatisfied with their care. A study found that "doctors who had longer average consultation lengths prescribed less and were more likely to include lifestyle advice and preventive activities. They also adopted a style of practice that enabled more problems to be dealt with and more information to be exchanged" (Wilson & Childs, 2002, p.1018). A consultation that only takes 10-15 minutes has little to no room for a more profound conversation between doctors and patients, which many Hispanic participants notice they lack when seeking health services. In a previous discussion with Dr. Aberham, he and other participants discussed having to take on a large caseload of patients every day, leaving little room for more in-depth conversation with patients they see, which may create a rush of consultation—however, the outcome of rushed consultation results from structural failures within the healthcare system.

The structural inability to provide effective and equitable resources to physicians across multiple health departments stems from the over-prioritization of profits. A prominent example of profits being prioritized over patients' access to equitable and efficient care is a report from the

---

[14] An experience that happened to me when I was seen by a doctor. And I told her what I was going to see was because I had pain in my fingers, the tips of my fingers. And she only touched my fingers. She sent me to the specialist as if I had a chronic disease that I was not going to cure. When I went to the specialist he asked me why I was going there. I told him that the doctor told me to go there, he said, "I shouldn't have sent you here because you don't have a chronic disease" as she should have seen me. And how fast it was because I have heard stories from different people that sometimes you go in, they see you for 5 or 10 minutes and they don't even talk to you, they don't even talk to you and then they don't do something like that, that's what happened to me. She was there for this, that if it was for that, and she said to me, "Do you have arthritis? Go to this specialist who specializes in arthritis?" And he told me, "You don't have arthritis. Here are the photos of people who have arthritis."

Senate “highlights systemic issues with PE investment in health care, including underinvestment in the critical hospital infrastructure, understaffing, and the pursuit of financial gains through leveraged buyouts and dividend extractions—often to the detriment of patients and hospital operations.”(Degen, 2025, p.1). This prioritization of profits over equitable care does not go unseen by the Hispanic population, which leads to the assumption of physicians' role in profit exchanges within the healthcare system.

Many individuals have, in some form, expressed distrust of health providers, specifically regarding physicians' role in obtaining healthcare insurance. Many Hispanic individuals who were interviewed showed their anger and frustration over doctors, specifically as they believe certain healthcare services are withheld based on the insurance that they have. The first person to bring this topic up was Samantha after being asked about her opinion on the healthcare system as a whole, like insurance. She responded:

> El sistema es tan corruptivo que él es lo único que les importa es ganar dinero. Y más que estes enfermo tu mas gastas. A ellos no le importa que te estas muriendo, ello no son los que se están muriendo eres tú. Eso y las farmacias ósea es un conjunto de nada más para robar dinero porque te solucionan un problema de, pero- por eso los hispanos si le duelen el estómago se toman un tea de manzanilla”
>
> Hay eso de las seguranzas no sirven hija es un robo porque nomas te ponen ahí que ellos pagan este por ciento y este por ciento y al final como quiere tu sales pagando ocho mil o depende a lo que vallas al hospital. Entonces de que te sirve pagando 20 años de seguranza y que no la usas y la única vez que lo uses tienes que pagar un chingo.[15]

---

[15] The system is so corrupt that the only thing they care about is making money. And the more you are sick, the more you spend. They don't care that you are dying, they are not the ones who are dying, it is you. That and the pharmacies, that is, they are a group of just to steal money because they solve a problem for you, but that is why Hispanics drink chamomile tea if they have a stomachache. There is that thing about insurance, it is useless, daughter, it is a robbery because they just put there that they pay this percentage and this percentage and in the end, as they want, you end up paying eight thousand or depending on what you go to the hospital for. So what good is it to you paying 20 years of insurance and not using it and the only time you use it you have to pay a lot.

For Samantha, the relationship between her and her doctors and the services she can receive is based on how much the physician and the clinic can profit from it. In other words, depending on how much an insurance company is willing to pay for a patient's exams, treatment, consultation, etc, the doctor will decide how much and what kind will be requested. Many Hispanic participants believe that physicians get a portion of how much they can have a patient receive a specific treatment or test through how much the insurance covers. Overall, the perception of the physicians and every aspect of the healthcare system is based on profits for Hispanic individuals. Yasmine's husband, Carlos, who has lived his whole life in the United States, understands the healthcare system.

> Everything has the price right, and I had a a specific medication that I was using that was working great the whole night, and then the new year came around, and insurance changes like policies. Insurance changes out of pricing, so then they refuse to pay for that. That medication they wanted me to choose or try a generic version of the medication. They would have thrown a wrench and forcing me to have to try a different alternative for this thing, saving a dollar.

A participant by the name of Mary takes a similar stance on prioritization in the United States healthcare system. Mary was asked about her difficulty in obtaining health insurance after disclosing that she does not have one, her answer follows:

> No, no es fácil. Porque a veces para calificar pues tienes que ganar cierta cantidad de dinero y si tú no la ganas, pues no te no te califican. […] Porque aquí lo que controla el mercado es las aseguranzas. No por eso, sino las aseguranzas a las que controlan todo el sistema de cuando la gente se enferma, los ves allá en México no tienes que pasar por eso. Si tú tienes, si tú llevas dinero, tú puedes ir a un especialista. Atiendan muy bien y te den muy buena medicina y no tienes que no te tienen que poner ninguna condición como aquí que las aseguranzas. A donde ellos quieren y no te aceptan, a veces en una te mandan un clon, entonces aquí siempre tienes que estar amarrado con la aseguranza y ya

> en México. Hay una cosa que los las los doctores o las clínicas se aprovechan cuando ellos pues saben que tú tienes aseguranza.[16]

The possibility of physicians profiting from requested exams and treatments seems unlikely, as many physician participants have stated that their clinic or hospital provides staff that works and handles patients coming in with insurance and pays for the services that they receive. This distrust between physicians and the healthcare system is not solely about cost but about the perceived prioritization of profit over the delivery of quality care for the well-being of a patient in the system. Researchers studying the Hispanic Health Paradox do not discuss this prioritization of profits over patient care because, for them, the U.S. constant investment, as previously mentioned, means that patients receive the "best care". However, the efficiency in providing the "best care" is often overlooked when discussing disproportional health outcomes in minority groups like Hispanics.

Samantha's description and perception of the corrupt healthcare system stems from the constant unsatisfied experiences of having and not having the financial means to pay for health services, which leads her to believe that it drives medical decisions from a systemic and individual aspect. This feeling can then construct the feeling of being underserved and isolated from other groups of people in the United States. In Mary's case, the difficulty that she and many others experience in obtaining health insurance reveals the control of access not only insurance

---

[16] No, it is not easy. Because sometimes to qualify you have to earn a certain amount of money and if you do not earn it, then you are not qualified. […] Because here what controls the market is the insurance companies. Not because of that, but the insurance companies control the whole system. When people get sick, you see them in Mexico, you do not have to go through that. If you have, if you have money, you can go to a specialist. They treat you very well and give you very good medicine and you do not have to put any conditions on you like here with the insurance companies. Wherever they want, they do not accept you, sometimes they send you a clone, so here you always have to be tied to the insurance company and already in Mexico. There is one thing that the doctors or the clinics take advantage of when they know that you have insurance.

companies have but also how physicians may play an unconscious role in facilitating this perception. The accumulation of biases, distrust, and discrimination that Hispanic individuals face leads to the use of outside means to receive care.

Seeking Healthcare Outside the U.S

With the majority of participants experiencing rush appointments while also perceiving a dismissal by their health concerns, most Hispanic individuals are left with little to no choice but to seek alternative ways to solve their health concerns. For many, their only option is to seek healthcare from outside the country. So was the case for Samantha when she stated:

> Lo que paso es cuando tuve mi primer hijo se me agravo ese dolor y me tuve que ir a México. I haya tenía la vesícula que ya me está muriendo y aquí no me lo detecto el doctor ose no pudiera decir ‘okay te voy aser un sonograma para ver que es porque lla es muy constante y vienes por lo mismo y lo mismo.
>
> No es qué allá los doctores obviamente te cobran y si vas a un especialista en particular porque allá hay públicos particulares. Si vas con un particular obviamente te cobran pero también hay unos doctores que son mejores que otros unos tienes más experiencia que otros como todo aquí es igual. Pero obviamente yo me fui es porque dije yo me voy a morir de ese dolor y aquí no me dicen nada. Si el me hubiera dicho ‘sabe que le tenemos que hacer un sonograma para identificar cual es su problema y el sonograma cuesta tal tal’. Lla es opción pagar o no, pero es mi derecho que me diga pues’ si ya cinco ves voy y no se me quita lo que tengo eso ya es obviamente es tener que tomar otra decisión’. Por esa cuestión allá si vas y pagas te dan la consulta y te dicen mas o menos y si no están seguros te dan estudios de sangre y obviamente pagan. Pero si vas enfermo obviamente tu lo que quieres hacer es encontrar que es el problema no nada mas que te den medicamento y que ya ‘vete y lla regresar otra vez por el mismo problema.[17]

---

[17] What happened is when I had my first child, the pain got worse and I had to go to Mexico. I had a gallbladder that was already dying and the doctor here couldn't detect it, so he couldn't say, 'okay, I'm going to do an ultrasound to see what it is because it's always very constant and you come for the same thing over and over again.'
It's not that there the doctors obviously charge you and if you go to a private specialist because there are private ones. If you go to a private one, obviously they charge you, but there are also some doctors who are better than others, some have more experience than others, like everything here is the same. But obviously I left because I said I'm going to die from this pain and here they don't tell me anything. If he had told me, 'you know, we have to do an ultrasound to identify what your problem is and the ultrasound costs such and such.' It's an option to pay or not, but it's my right to tell me, 'if I go five times and what I have doesn't go away, then obviously I have to make another

Hispanic participants like Pedro, who have had experience in seeking healthcare in Latin countries, have stated similarly as he has:

> Si vas a México a ver un doctor, él te da una receta, verdad? Ver esta receta y ve a toda la farmacia, vas a la farmacia y ninguna pregunta de nada te dan la receta .Lo que pasa que en México, como te digo en México, si vas a ver un doctor privado, pues. Y tienes hay gente que está operando. El doctor se tarda contigo, mínimo, mínimo. 30-40 minutos mínimo porque te- porque platica contigo. ¿Dice, tienes problemas? ¿Te preocupa algo? Miras cuando te levantes en la mañana pero vamos, no es al otro, se hace, se se hace una relación. No, aquí te ves como te ven como un número.[18]

Pedro's comparison between U.S. healthcare and Mexico highlights how, for many Hispanic individuals like himself, most health consultations feel impersonal and more of a transactional relationship. He, along with many other Hispanic participants who prefer or actively seek out health services outside the country, demonstrates the failure of the U.S. healthcare system in meeting not only the health needs of Hispanic patients but also the ability to build trusting relationships with providers. Of course, some Hispanic individuals are also driven by financial restraints given the high cost of medical procedures; however, for many, this aspect only partially influences their decision. In Smanthas's statement, she encountered a physician who did not want to delve deeper into her pain. This lack of action can then be tied to the physician's assumption in whether he believes the extent of Samantha's pain and worries, which

---

decision.' For that matter, if you go and pay, they give you a consultation and they tell you more or less, and if they are not sure, they give you blood tests and obviously you pay. But if you go sick, obviously what you want to do is find out what the problem is, not just give you medicine and then go back again for the same problem.

[18] If you go to Mexico to see a doctor, he gives you a prescription, right? You see this prescription and you go to the whole pharmacy, you go to the pharmacy and you don't ask anything and they give you the prescription. What happens is that in Mexico, as I told you in Mexico, if you go to see a private doctor, well, and you have people who are operating. The doctor takes at least 30-40 minutes with you because he talks to you. He says, do you have problems? Are you worried about something? You look at it when you get up in the morning, but come on, it's not about the other person, it's done, a relationship is established. No, here you see yourself as they see you as a number.

may have led to her possibly encountering severe health problems if she did not seek medical care outside of the U.S.

However, there are medical providers like Yasmine, who works as a cancer clinic nurse, who knows Hispanics can, at times, seek out medical help outside the U.S. as a risk to the individual's health. She states:

> For medications that cost a buttload of money, like our cancer medications, cost like $4000 a month. Literally, that's with insurance. But there's lots and lots of foundations. There are many things to help, but my issue with Mexico and their opposite is. Oh yeah, let's just go get some of my selling over the counter. Let's just do that. That's also why things are hard to treat because they go often. But it's not necessary. Now we have superbugs. So I think that they have it, they have it too accessible over there. They're building tolerances.
>
> So I mean, I agree, like it's right that it's a lot better that you don't have to pay for everything all the time, you know. But I think that like everybody's popping up selling for everything when they don't need it. So when you do need it, your body's not going to do anything for you.

Health providers like Yasmine have raised valid concerns regarding the health risks in medical tourism, such as antibiotic tolerance and, therefore, the development of super drugs, which could lead to another health risk for individuals. These possible health risks need to be understood within the context of the systemic failure of U.S. healthcare. Many Hispanic patients do not seek foreign treatment out of preference, as some physician participants have suggested, but out of necessity. The necessity stems from constant experiences of biases, discrimination, rush consultations, over-prioritization of profits, and dismissal, which have ultimately left many Hispanics little to no choice but to travel to seek the care they need despite such health risks. Those who are undocumented, who cannot leave the country, oftentimes self-treat symptoms and illness to the point where their illness or diseases may manifest in a severe state of health.

The Hispanic Health paradox has assumed that Hispanic individuals have an inherent health advantage and that the decline of these positive health outcomes is a result of individual behavior. However, Hispanic patients' statements of their experiences, perceptions, and reliance on traveling to receive healthcare challenge the false existence of the “paradox.”. The paradox can only exist within a flawed and unrealistic expectation and assumptions of Hispanic individuals' engagement in health and the effective ability of U.S. healthcare to provide care to all populations. If U.S. healthcare were genuinely effective in distributing healthcare across all populations, fewer patients would feel the need to take on the risks associated with medical tourism. Additionally, we would not see such persistent levels of avoidance and dissatisfaction in the interviews conducted for this study. Understanding that the decline of Hispanic Health outcomes is a ‘paradox’ hides what is the result of a healthcare system that fails to provide long-term, equitable care for the Hispanic population. Even though the experiences that participants discussed happened under specific contexts, these events don’t exist individually but as a puzzle piece that keeps health disparities in the Hispanic community the same over generations. Therefore, it is necessary for not only academic scholars but also physicians to move away from a narrow understanding of how healthcare disparities in the U.S are reinforced to properly reflect and organize ways in which healthcare can be reformed for vulnerable populations like Hispanics to feel safe and secure in seeking care in the United States.

CONCLUSION:

My goal for this study was to acquire a better understanding of why there have been consistently low levels of health service utilization and the persistent existence of health inequalities within the Hispanic population in the United States. I was initially interested in evaluating how the language landscape influences these outcomes despite the country's efforts in investing trillions of dollars into its healthcare system. However, after carefully analyzing both Hispanic and physician participants' interviews, my research led me to engage with a well-documented phenomenon in medical literature known as the Hispanic Health Paradox. As discussed, the paradox has shown that Hispanic immigrants demonstrate better health outcomes compared to the general population in the U.S.

This study critically examined the “Hispanic Health Paradox” in how it has been used to discuss Hispanic health outcomes to obscure the reality that Hispanics face in accessing healthcare in the United States. While medical research on the Hispanic Health Paradox suggests that Hispanic immigrants have a health advantage despite social and economic disadvantages, my findings reveal that his perspective fails to account for systemic issues that are deeply embedded in the country's healthcare system. This study challenges the validity of the Hispanic Health Paradox by documenting Hispanic Patients' lived experience, through qualitative research with Hispanic Patients and Physicians. Hispanic lived experiences have demonstrated systemic failures that continue to shape healthcare access and inequalities, rather than individual shortcomings, within the community. Additionally, this study has examined the relationship between physicians and Hispanic patients by exploring how individual responsibility frameworks have shaped physicians' perceptions of Hispanic disparities and perpetuated structural inequalities in healthcare delivery and access. Individual responsibility has been carefully integrated within healthcare providers' understanding of health, as it focuses on patient behavioral issues rather than existing structural ones.

I have often wondered how a country known for its immense wealth and advanced medical technology could continue to exhibit such significant health inequalities. This study is important to me because, before conducting my research, I was unaware that there have been extensive debates surrounding the “unusual” trend that Hispanics have “better health” despite constantly being exposed to experiences of mistreated, discriminated, and dissatisfaction over the years. I also did not fully grasp how deep structural issues have been woven through the medical training and physicians’ perspectives. I learned how physician participants have been carefully shaped to self-regulate and utilize similar individualistic frameworks through power and habitus. Shifting focus away from systemic failures and reinforcing the current form of the healthcare system. It has then demonstrated to me that physicians need to break away from these limited perspectives and actively, as a community, reflect and engage in reform of the healthcare system. Additionally, Hispanic participants have taught me how their experiences, perceptions, and understandings of healthcare access and delivery ultimately shatter medical debate when discussing the “paradox”. Through their voices I learned how resilient the Hispanic community is to the U.S. healthcare system's inability to provide equal and efficient care.

This study relied on 13 Hispanic participants and nine physician participants. Although this study is essential in demonstrating a snapshot of the experience and structure of the healthcare system, it does not include the totality of Hispanic healthcare experiences in the U.S healthcare system. The Hispanic community consists of various languages, cultures, and many other intersecting positionalities that can influence Hispanics' lived experience within the country's healthcare system. Additionally, as demonstrated through physicians' participant interviews, not all physicians work in the same environment and have available resources; therefore, it is expected that different specialized medical practices train and influence physicians' perceptions of healthcare disparities within the Hispanic community differently. Consequently, I hope that in the future expansion of this study, it will be able to expand on the diversity within these two sample groups.

If I were to expand this research, I would narrow down specific and more extensive subgroups of Hispanic and physician participants to further examine health inequality within the Hispanic community. This approach would provide a more nuanced understanding of different intersecting positionalities and experiences within the Hispanic community in the United States. It would also help to consider physicians' complexities when entering the healthcare system. Additionally, given that this study relied on participants' experiences, I would also attempt to conduct a more observational approach to observe doctor-patient interactions, to compare Hispanic patients and physicians directly. As I consider different ways to expand this study, it is also essential to consider the ongoing changes in healthcare policy in the U.S. healthcare system that may further worsen disparities for vulnerable populations like Hispanic communities.

The current changes in healthcare policy, as recent executive orders, such as the rescinding of the Affordable Care Act, will make it difficult for minority groups, like Hispanics, to have access to Medicaid and other forms of health services (Morcelle, 2025). While those who are Undocumented are at a higher risk of deportation as Immigration and Customs Enforcement is encouraged to enter medical spaces like clinics and hospitals (*The Trump Administration's Immigration Enforcement Policy*, 2025). As new orders and policies evolve, it is crucial to explore and consider how existing systemic healthcare issues have been carefully enforced and interwoven within the medical staff's perception of their healthcare roles. To understand its persistent influence on vulnerable communities, like Hispanics, right to healthcare. Without a more meaningful and in-depth understanding of the need for systemic reform, these disproportional health outcomes will likely continue and worsen across the United States. It is then through critically examining how the U.S healthcare system, we can hope to create a healthcare system that provides equal and effective care to all.

APPENDIX

A. Oral consent script for Hispanic Participants: Spanish Version

Introducción y descripción general del estudio

Gracias por su interés en nuestro estudio de investigación sobre el idioma. Nos gustaría decirle lo que debe tener en cuenta antes de decidir si participar o no en el estudio. Es su decisión. Si decide participar, puede cambiar de opinión más adelante o abandonar el estudio. No hay ninguna penalización por no participar o abandonar el estudio.

El propósito de este estudio es comprender mejor cómo las diferencias lingüísticas hacen que los pacientes hispanos sean reacios a confiar en los diagnósticos y tratamientos de los médicos, y cómo los obstáculos para acceder a la atención médica afectan la autopercepción de los hispanos dentro del sistema de atención médica. Su participación en este estudio será una entrevista única.

Si participa, se le pedirá que participe en una entrevista en persona de 1 hora en un lugar y horario acordados. Se le harán preguntas sobre sus experiencias generales en las citas con el médico y su experiencia en la búsqueda de una cita con el médico.

Puede decidir cómo desea que se registren sus respuestas durante la entrevista:

☐Grabación de audio

☐Notas escritas a mano

Es posible que haya momentos de incomodidad durante la entrevista al recordar sus experiencias en las citas médicas. Usted es libre de no responder las preguntas que desee. También tendrá la opción de aclarar o retirar declaraciones durante la entrevista.

Es posible que no se beneficie de participar en el estudio. No se le pagará por participar en este estudio. Este estudio está diseñado para aprender más sobre la imagen y el uso del lenguaje dentro de la atención médica y comprender las relaciones entre los pacientes hispanos y los médicos. Los resultados del estudio pueden usarse para ayudar a otros en el futuro.

Almacenamiento y compartición de su información

Almacenaremos todos los datos que nos proporcione utilizando una carpeta electrónica protegida con contraseña dentro de un escritorio protegido con contraseña que solo compartirá el presidente del comité de tesis. Se le proporcionará un seudónimo para que podamos realizar un seguimiento de sus datos a lo largo del tiempo. No registraremos ni incluiremos información que pueda identificarlo (identificadores). Específicamente, no incluirá su nombre, iniciales, fecha de nacimiento, ciudadanía o número de historial médico.

No permitiremos que su nombre ni ningún otro dato que pueda apuntar hacia usted aparezca cuando presentemos o publiquemos los resultados de este estudio.

Sus datos pueden ser útiles para otras investigaciones que realicen investigadores de Emory o de otros lugares. Podemos compartir los datos con otros investigadores de Emory o con investigadores de otras instituciones que mantengan al menos el mismo nivel de seguridad de datos que mantenemos en Emory.

Devolución de resultados a los participantes/hallazgos incidentales

Los resultados de la investigación no se compartirán directamente con usted ni con otros participantes de este estudio.

Confidencialidad

Ciertas oficinas y personas distintas de los investigadores pueden consultar los registros del estudio. Las agencias gubernamentales y los empleados de Emory que supervisan la realización adecuada del estudio pueden consultar sus registros del estudio. Estas oficinas incluyen [la Oficina de Protección de la Investigación Humana, los financiadores, la Junta de Revisión Institucional de Emory, la Oficina de Cumplimiento de Emory]. Los financiadores del estudio también pueden consultar sus registros del estudio. Emory mantendrá la privacidad de los registros de investigación que creemos en la medida en que la ley nos lo exija. En los registros del estudio se utilizará un número de estudio en lugar de su nombre siempre que sea posible. Su nombre y otros datos que puedan apuntar a usted no aparecerán cuando presentemos este estudio o publiquemos sus resultados.

Información de contacto

Si tiene preguntas sobre los procedimientos del estudio, la entrevista u otras preguntas o inquietudes sobre la investigación o su participación en ella, o si desea retirarse del estudio, comuníquese con la Dra. Marsilli-Vargas al 404-727-6233:

Este estudio ha sido revisado por un comité de ética para garantizar la protección de los participantes de la investigación. Si tiene preguntas sobre sus derechos como participante de la investigación, o si tiene quejas sobre la investigación o un tema que preferiría discutir con alguien fuera del equipo de investigación, comuníquese con la Junta de Revisión Institucional de Emory al 404-712-0720 o al 877-503-9797 o irb@emory.edu.

Para contarle al IRB sobre su experiencia como participante de la investigación, complete la Encuesta para participantes de la investigación en https://tinyurl.com/ycewgkke.

Consentimiento

¿Tiene alguna pregunta sobre lo que acabo de decir? ¿Hubo alguna parte que no le pareció clara?

¿Está de acuerdo en participar en el estudio?

El participante acepta participar: Sí No

B. Oral Consent Script for Hispanic Participants: Translated English Version

Introduction and Study Abstract

Thank you for your interest in our research study. We would like you to be well-informed before you decide whether or not to participate in the study. The decision is yours. If you decide to participate, you can change your mind later and drop out of the study. There is no penalty for not participating or leaving the study.

The goal of this study is to better understand how language differences make Hispanic patients distrustful of doctors' diagnoses and treatments in the United States. And how barriers to healthcare access affect Hispanics' self-perceptions of the healthcare system. Your participation in this study will consist of a single interview.

If you wish to be part of the study, you will be asked to participate in a one-hour, in-person interview at a pre-arranged time and place. You will be asked questions about your experiences during your doctor's appointments and about your experience in trying to schedule a doctor's appointment

You can decide how you want your answers to be saved during the interview. Via:

☐ Audio recording

☐Handwritten notes

There may be some awkward moments during the interview as you reminisce about your experiences during your medical appointments. You may not answer questions that you do not want to. You will also have the option to clarify or withdraw statements throughout the interview.

You will not receive any tangible benefit for participating in the study. You will not be paid for participating. This study is designed to learn more about language use during the medical appointment and to understand more about the relationships between Hispanic patients and physicians. The results of the study may be used to help others in the future.

Storage and use of your information

We will store all the data you provide using a password-accessible electronic folder on a password-accessible computer that will only be shared with the thesis committee chair. You will be assigned a pseudonym so that we can continue to use the information you provide over time. We will not record or include information that can identify you (identifiers). In particular, we will not include your name, initials, date of birth, nationality, or medical record number.

The information you provide may be useful for other research conducted at Emory or other universities. We would only share the information you provide with other Emory researchers or researchers at other institutions that maintain the same level of security that we maintain at Emory.

Incidental Results/Discoveries

Research results will not be shared directly with you or other participants in this study.

Confidentiality

Certain offices and personnel who are not investigators may see study records. For example, government agencies and Emory employees who oversee the proper conduct of the research may see the records. These offices include [the Office for the Protection of Human Subjects in Research, the funder(s), Emory's Institutional Review Board, Emory's Office of Compliance]. Study funders may also consult their records. Emory will maintain the confidentiality of all research records to the extent that we are required to do so by law. Whenever possible, a study number will be used in place of your name on study records. Your name and other information that may recognize you will not appear when we present this study or publish its results.

<u>Contact us at:</u>

If you have questions about the study procedures, the interview, or other questions or concerns about the research or your participation in it, or if you wish to withdraw from the study, please contact Dr. Marsilli-Vargas at 404-727-6233:

This study has been reviewed by an ethics committee to ensure the protection of research participants. If you have any questions about your rights as a research participant, or if you have a complaint about the research or an issue you would prefer to discuss with someone outside the research team, please contact Emory's Institutional Review Board (IRB) at 404-712-0720 or 877-503-9797 or irb@emory.edu.

To inform the IRB about your experience as a research participant, please fill out the research participant survey at this link: https://tinyurl.com/ycewgkke.

<u>Consent</u>

Do you have any questions about what I have just said, and was there anything that was unclear to you?

Do you agree to participate in the study?

Yes No

C. Oral Consent Script for Physician Participants

Introduction and Study Overview

Thank you for your interest in our language research study. We would like to tell you what you need to think about before you choose whether or not to join the study. It is your choice. If you choose to join, you can change your mind later on and leave the study. There is no penalty for not participating or leaving the study.

The purpose of this study is to better understand how language differences cause Hispanic patients to be reluctant to trust doctors' diagnosis and treatments. And how obstacles in accessing healthcare affect Hispanics' self-perception within the healthcare system. Your participation in this study will be a one-time interview.

If you join, you will be asked to participate in a 45-minute interview on zoom at an agreed upon time. You will be asked questions about your general experiences in doctor appointments with Hispanic patients and your opinion on topics regarding access to health.

There may be moments of discomfort during the interview in remembering your experiences in doctor appointments. You are free not to answer any questions you wish. You will also have the option to clarify or withdraw statements throughout the interview.

You can decide how you want your responses to be recorded during the interview:

- ☐Audio recording
- ☐Handwritten notes

You may not benefit from joining the study. You will not be paid for participating in this study. This study is designed to learn more about the image and use of language within health care and understand the relationships between Hispanic patients and doctors. The study results may be used to help others in the future.

Storing and Sharing your Information

We will store all the data that you provide using a password locked electronic folder within a password locked desktop that will only be shared by the chair of the thesis committee. You will be given a *pseudonym* so that we can keep track of your data over time. We will not record or include information that can identify you (identifiers). Specifically, it will not include your name, initials, date of birth, citizenship, or medical record number.

We will not allow your name and any other fact that might point to you to appear when we present or publish the results of this study.

Your data may be useful for other research being done by investigators at Emory or elsewhere. We may share the data, with other researchers at, or with researchers at other institutions that maintain at least the same level of data security that we maintain at *Emory*.

Returning Results to Participants/Incidental Findings

Research results will not be directly shared with you or other participants in this study.

Confidentiality

Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at your study records. These offices include [the Office for Human Research Protections, the funder(s), the Emory Institutional Review Board, the Emory Office of Compliance]. Study funders may also look at your study records. Emory will keep any research records we create private to the extent we are required to do so by law. A study number rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results

Contact Information

If you have questions about the study procedures, interview, or other questions or concerns about the research or your part in it, or if you wish to withdraw from the study, contact Dr. Marsilli-Vargas at 404-727-6233:

This study has been reviewed by an ethics committee to ensure the protection of research participants. If you have questions about your rights as a research participant, or if you have complaints about the research or an issue you would rather discuss with someone outside the research team, contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu.

To tell the IRB about your experience as a research participant, fill out the Research Participant Survey at **https://tinyurl.com/ycewgkke.**

Consent

Do you have any questions about anything I just said? Were there any parts that seemed unclear?

Do you agree to take part in the study?

Participant agrees to participate: Yes No

D. Interview Guide for Hispanic Participants: Spanish Version

1. .¿Se identifica usted como hispano/latino?
    a. ¿Cuál fue tu primer idioma?

2. ¿Utilizas tu primera lengua con mucha frecuencia? ¿En un entorno profesional o personal?¿Cuánto tiempo ha vivido en Atlanta Georgia?
    a. Desde el momento en que residió en Atlanta, ¿Cuántas veces aproximadamente ha acudido a un médico de atención primaria?
    b. ¿Con qué frecuencia cree que necesita una consulta con un médico?

3. ¿Hay alguna razón particular por la que haya sido visto por un médico a X veces, ya sea por preferencia personal, autoevaluación, etc.?

4. Si hablas español con mayor fluidez, ¿cuántas veces has necesitado que alguien te ayude con la traducción en las consultas médicas?
    a. ¿Cuántas veces se ha ofrecido? ¿Se siente vulnerable a la hora de pedir un traductor a las clínicas?

5. Cuando no había traductores disponibles para sus consultas, ¿sintió que sus preguntas fueron respondidas y sintió que el médico respetaba sus preocupaciones sobre su salud?
    a) Dependiendo de su respuesta, ¿sientes que es o hubiera sido diferente si hubiera un traductor allí? ¿Se habría sentido más escuchado o percibido de cierta manera si tuviera a alguien que lo tradujera?
    b) ¿Alguna vez ha notado que los médicos y las enfermeras cambian su estado de ánimo o sus respuestas cuando escuchan por primera vez que usted puede necesitar ayuda con las traducciones al inglés? ¿Es algo que dicen, la forma en que lo dicen o lo que hacen?

6. ¿Hubo alguna consulta en particular que se le haya quedado grabada en la que se haya sentido juzgado o ignorado debido a su uso del lenguaje?
    a) ¿Ha tenido casos en los que los médicos, enfermeras o empleados de la clínica lo percibieron de cierta manera debido a que necesitaban ayuda con las traducciones al inglés? Si es así, ¿qué crees que percibieron?
    b) ¿Cómo te hizo sentir? ¿Alguna vez volviste? por qué o por qué no? ¿Tuvo la opción de cambiar de clínica/médico?
    c) ¿Sientes que si hablaras inglés fluido te habrían tratado diferente?
    d) ¿Por qué crees que pudieron haber respondido de determinadas maneras?

7. ¿Alguna vez se ha sentido reacio a tomar medicamentos o seguir un tratamiento de un médico que habla inglés? Si es así, ¿hay alguna razón particular por la que tenga renuencia?

8. ¿Siente que la experiencia previa con médicos y clínicas ha moldeado su forma de afrontar las consultas? ¿De qué maneras? ¿Tiene una noción preconcebida de lo que los

médicos o enfermeras pueden percibir de usted? ¿Tienes formas de manejar esta percepción?

9. ¿Cree que se podría mejorar las relaciones entre los hispanos y los cuidadores permitiendo que se ofrezcan más fondos para que se ofrezcan más traductores en las clínicas? ¿O crees que se puede hacer más? ¿Si es así, de qué manera?

10. ¿Puede describirme lo difícil que es poder obtener un seguro y al mismo tiempo intentar encontrar un médico que esté incluido en su cobertura de seguro?
    e) ¿Qué encuentra en común cuando intenta obtener ayuda de agentes de seguros cuando no hablan español con fluidez? ¿Sientes que responden respetuosamente a tus preguntas?

11. ¿Cómo te ha sentido saber que probablemente tendrás que hablar sobre tu seguro con alguien que no habla español?
    a) Con los desafíos que conlleva el seguro, ¿crees que es más difícil para un hispano obtener un seguro?
    b) ¿Cómo crees que lo ve el estado/gobierno y lo ve en la forma en que lo tratan en el sistema de atención médica?

12. ¿Cuál ha sido tu experiencia al interactuar con el personal de la clínica? ¿Cree que las personas que trabajan en la recepción suelen ser personas que no son blancas?
    c) ¿Te sientes más comprendido o tratado con respeto cuando hablas español o incluso inglés?
    d) ¿Es diferente cuando se trata de alguien que sabe español y de aquellos que no? ¿Qué sientes que es diferente? ¿Te tranquiliza? ¿Por qué o por qué no?
    e) Si entiendes inglés pero puede que tengas acento al hablar ¿sientes que te tratan de cierta manera?

E. Interview Guide for Hispanic Participants: English Version

1. How long have you lived in ________?
    a) From the time you have resided in Atlanta around how many times have you gone to a primary care physicians
    b) How often do you believe that you need a consultation with a physician?
2. Is there any particular reason you have been seen by a physician _ amount of times whether that is by personal preference, self-assessment etc.?
3. Do you identify as Hispanic/Latino?
    a) What was your first language?
    b) Do you use your first language very often? In a professional or personal setting?
4. If you are more fluent in Spanish how many times have you needed someone to help with translation with physician consultations
    a) How many times has it been offered? Do you feel vulnerable about asking clinics for a translator?
5. When translators were not available for your consultations did you feel that your questions were answered and did you feel that the doctor respected your concerns about your health?
    a) Depending on your answer do you feel like it is or would have been different if a translator was there? Would you have felt more heard or perceived in a certain way if you did have someone to translate
    b) Were there ever times you have noticed doctors, and nurses shift their mood/responses when they first hear that you may need assistance with English translations? Is it something they say, the way they say it, or what they do?
6. Was there any particular consultation that has stuck with you where you felt judged or ignored due to your use of language?
    a) Have you had instances where doctors, nurses, or clinic employees perceived you a certain way due to needing aid with English translations? If so, what do you believe they perceived?
    b) How did it make you feel? Did you ever go back why or why not? Did you have the option to change clinics/physicians?
    c) Do you feel that if you spoke fluent English, they would have treated you differently?
    d) Why do you think they may have responded in these certain ways?

7. Have you ever felt reluctant to take medication or follow treatment from an English-speaking physician? If so is there any particular reason you have reluctance?

8. Do you feel that previous experience with physicians and clinics have shaped the way you navigate consultations? In what ways? Do you have a preconceived notion of what

physicians or nurses may perceive of you? Do you have ways in which you handle this perception,

9. Do you believe that improving relationships between Hispanics and caregivers could be solved by allowing more funding for more translators to be offered in clinics? Or do you think more can be done? If so in what ways?

10. Can you describe to me how challenging it is to be able to obtain insurance while also trying to find a physician that falls under your insurance coverage?
    a) What do you find common when trying to get help from insurance agents when they are not fluent in Spanish? Do you feel that they respectfully answer your questions?

11. How has it made you feel when you know you will most likely have to discuss your insurance with someone who does not speak Spanish?
    a) With the challenges that come with insurance do you believe it is harder as a Hispanic individual to get insurance?
    b) How do you feel the state/government sees you and do you see it in the way you are treated in the health care system?

12. What has your experience been when interacting with the staff of the clinic? Do you feel that the people who work at the front desk often consist of non-white individuals?
    a) Do you feel more understood or treated with respect when you speak Spanish or even English?
    b) Is it different when its someone who knows Spanish and those who don't? What do you feel is different? Does it put you at ease? Why or why not?
    c) If you understand English but you may have an accent when speaking it do you feel that you are treated a certain way?

F. Interview Guide for Physician Participants

1. How long have you worked as a physician here in Atlanta Georgia?
    a) How frequently during your time here have you had patients who identified as Hispanic/spoke mainly Spanish compared to English-speaking patients
    b) Does your clinic offer translators for non-fluent English speakers?

2. Do you speak fluent English? Is it your first language? Do you speak fluent Spanish? Do you feel that you need to learn Spanish or do you feel that the resources provided in the clinic are enough for you to treat Hispanic patients with the same effectiveness as those who are not Hispanic?

3. Do you feel that everyone should go to the doctor frequently? Why do you think some people, especially Hispanics, don't usually go?

If they don't speak Spanish 4-6:

4. Have there ever been instances in which a Spanish translator was needed for a patient but was not available at that moment?
    a) Can you describe how effective the consultation is when there is no translator? Do you feel that the patient can be more reluctant, and uncomfortable to disclose certain things to you?
    b) Why do you think some patients can respond like this?
    c) In response to this do you often change certain things on how you approach certain subjects during the consultation?

5. Have you ever had instances where your patients requested that their family member or friend sit with them through the consultation to translate for them?
    a) Does this form of translation better or complicate consultations when figuring out the patient's health concerns or issues?
    b) Why do you think some might prefer to have someone they know translate for them even though they may not be equipped to translate accurately?
    c) Do you personally prefer for a patient to have a family member or friend translate for them or a translator that is provided by the clinic?

6. How well do you know the people who are translators? How often do you see them outside a consultation? Do translators often stay for a long period at the same clinic?

7. Have you ever felt that some Hispanic patients that you have encountered seem to be guarded when not only discussing certain information with you but with other members of the staff like nurses or front desk receptionists?

    a) If so what made you be perceptive when you felt like they did seem guarded or hostile? Was it their voice? Their body language etc.

8. . In instances where you perceive that a Hispanic patient is not satisfied with the consultation do you feel that there is anything that you or the staff could have done differently? If so what?

9. Do you often try to make a connection with your patience? If so what do you do? What so you think Hispanic individuals look for a doctor?

10. Do you have difficulty in taking your time in consultations due to other important events or following appointments

11. How do you feel about people going to other countries to get care? Is there any issue involving that?

12. How effective do you think the healthcare system is in resolving the problem fast for a person? Why do you think some feel that it's less effective

13. What is your opinion regarding insurance? The good and the bad.

14. Do you feel that push for profits and capitalism have influenced the way the healthcare system goes about allocating resources

15. What are your thoughts on legality and big pharma

16. Do you feel anything should change regarding resources provided to non-english speaking patients? How do you think your clinic/hospital/health care can do to offer more accessible services to Hispanic communities?

17. What is your opinion regarding how Hispanic communities are perceived and treated within the healthcare system? What works what does work in the health care system?

BIBLIOGRAPHY

Achat, H., Kawachi, I., Levine, S., Berkey, C., Coakley, E., & Colditz, G. (1998). Social networks, stress and health-related quality of life. *Quality of Life Research*, *7*(8), 735–750. https://doi.org/10.1023/A:1008837002431

Affairs (ASPA), A. S. for P. (2013, June 10). *Lifetime & Annual Limits* [Page]. https://www.hhs.gov/healthcare/about-the-aca/benefit-limits/index.html

Affairs (ASPA), A. S. for P. (2023, August 3). *New HHS Report Shows National Uninsured Rate Reached All-Time Low in 2023 After Record-Breaking ACA Enrollment Period* [News Release]. https://www.hhs.gov/about/news/2023/08/03/new-hhs-report-shows-national-uninsured-rate-reached-all-time-low-2023-after-record-breaking-aca-enrollment-period.html

Awaysheh, A., Wilcke, J., Elvinger, F., Rees, L., Fan, W., & Zimmerman, K. (2018). A review of medical terminology standards and structured reporting. *Journal of Veterinary Diagnostic Investigation*, *30*(1), 17–25. https://doi.org/10.1177/1040638717738276

Ayón, C., Ramos Santiago, J., & López Torres, A. S. (2020). Latinx Undocumented Older Adults, Health Needs and Access to Healthcare. *Journal of Immigrant and Minority Health*, *22*(5), 996–1009. https://doi.org/10.1007/s10903-019-00966-7

Beagan, B. L. (2018). A Critique of Cultural Competence: Assumptions, Limitations, and Alternatives. In C. L. Frisby & W. T. O'Donohue (Eds.), *Cultural Competence in Applied Psychology: An Evaluation of Current Status and Future Directions* (pp. 123–138). Springer International Publishing. https://doi.org/10.1007/978-3-319-78997-2_6

Benefits and drawbacks of electronic health record systems. (n.d.). https://doi.org/10.2147/RMHP.S12985

Boen, C. E., & Hummer, R. A. (2019). Longer—But Harder—Lives?: The Hispanic Health Paradox and the Social Determinants of Racial, Ethnic, and Immigrant–Native Health Disparities from Midlife through Late Life. *Journal of Health and Social Behavior*, *60*(4), 434–452.

Bonilla-Silva, E. (2021). What Makes Systemic Racism Systemic? *Sociological Inquiry*, *91*(3), 513–533. https://doi.org/10.1111/soin.12420

Boychuk, G. W. (2008). *National Health Insurance in the United States and Canada: Race, Territory, and the Roots of Difference*. Georgetown University Press. https://www.jstor.org/stable/j.ctt2tt2r5

Briggs, C. L. (2005). Perspectivas criticas de salud y hegemonia comunicativa: Aperturas progresistas, enlaces letales. *Revista de Antropologia Social*, 101–125.

Brosschot, J. F., Gerin, W., & Thayer, J. F. (2006). The perseverative cognition hypothesis: A review of worry, prolonged stress-related physiological activation, and health. *Journal of Psychosomatic Research*, *60*(2), 113–124. https://doi.org/10.1016/j.jpsychores.2005.06.074

Cabral, J., & Cuevas, A. G. (2020). Health Inequities Among Latinos/Hispanics: Documentation Status as a Determinant of Health. *Journal of Racial and Ethnic Health Disparities*, *7*(5), 874–879. https://doi.org/10.1007/s40615-020-00710-0

Camacho-Rivera, M., Kawachi, I., Bennett, G. G., & Subramanian, S. V. (2015). Revisiting the Hispanic Health Paradox: The Relative Contributions of Nativity, Country of Origin, and Race/Ethnicity to Childhood Asthma. *Journal of Immigrant and Minority Health*, *17*(3), 826–833.

Capell J, Veenstra G, & Dean E. (2007). Cultural competence in healthcare: Critical analysis of the construct, its assessment and implications. *Journal of Theory Construction & Testing*, *11*(1), 30–37.

Carpenter-Song, E. A., Schwallie, M. N., & Longhofer, J. (2007). Cultural Competence Reexamined: Critique and Directions for the Future. *Psychiatric Services*, *58*(10), 1362–1365. https://doi.org/10.1176/ps.2007.58.10.1362

Castro, F. G. (2013). Emerging Hispanic Health Paradoxes. *American Journal of Public Health*, *103*(9), 1541. https://doi.org/10.2105/AJPH.2013.301529

Chute, C. G., Cohn, S. P., Campbell, J. R., & for the ANSI Healthcare Informatics Standards Board Vocabulary Working Group and the Computer-based Patient Records Institute Working Group on Codes and Structures. (1998). A Framework for Comprehensive Health Terminology Systems in the United States: Development Guidelines, Criteria for Selection, and Public Policy Implications. *Journal of the American Medical Informatics Association*, *5*(6), 503–510. https://doi.org/10.1136/jamia.1998.0050503

Cohen, S., & Janicki-Deverts, D. (2009). Can We Improve Our Physical Health by Altering Our Social Networks? *Perspectives on Psychological Science*, *4*(4), 375–378.

Constitution of the World Health Organization. (n.d.). Retrieved December 8, 2024, from https://www.who.int/about/governance/constitution

Copayment—Glossary. (n.d.). HealthCare.Gov. Retrieved October 31, 2024, from https://www.healthcare.gov/glossary/co-payment

Currie, J., & Duque, V. (2019). Medicaid: What Does It Do, and Can We Do It Better? *The Annals of the American Academy of Political and Social Science*, *686*, 148–179.

Cutler, D. M., & Zeckhauser, R. J. (2000). The Anatomy of Health Insurance*. In A. J. Culyer & J. P. Newhouse (Eds.), *Handbook of Health Economics* (Vol. 1, pp. 563–643). Elsevier. https://doi.org/10.1016/S1574-0064(00)80170-5

Daundasekara, S. S., Arlinghaus, K. R., & Johnston, C. A. (2020). Quality of Life: The Primary Goal of Lifestyle Intervention. *American Journal of Lifestyle Medicine*, *14*(3), 267–270. https://doi.org/10.1177/1559827620907309

Degen, C. (2025). PE-owned healthcare puts "profits over patients" — report Senate report finds: Bipartisan Senate report cites underinvestment, financial extraction. *Pensions & Investments*, *53*(1), 28.

DeVries, A. C., Glasper, E. R., & Detillion, C. E. (2003). Social modulation of stress responses. *Physiology & Behavior*, *79*(3), 399–407. https://doi.org/10.1016/S0031-9384(03)00152-5

Duranti, A. (1993). Truth and Intentionality: An Ethnographic Critique. *Cultural Anthropology*, *8*(2), 214–245.

Escarce, J. J., & Kapur, K. (2006). Access to and Quality of Health Care. In *Hispanics and the Future of America*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK19910/

Fareri, D. S., & Delgado, M. R. (2014). Social Rewards and Social Networks in the Human Brain. *The Neuroscientist*, *20*(4), 387–402. https://doi.org/10.1177/1073858414521869

Farmer, P. (2009). On Suffering and Structural Violence: A View from Below. *Race/Ethnicity: Multidisciplinary Global Contexts*, *3*(1), 11–28.

Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Science & Medicine*, *103*, 7–14. https://doi.org/10.1016/j.socscimed.2013.09.006

Fernandez, J., García-Pérez, M., & Orozco-Aleman, S. (2023). Unraveling the Hispanic Health Paradox. *The Journal of Economic Perspectives*, *37*(1), 145–168.

Findling, M. G., Bleich, S. N., Casey, L. S., Blendon, R. J., Benson, J. M., Sayde, J. M., & Miller, C. (2019). Discrimination in the United States: Experiences of Latinos. *Health Services Research*, *54*(S2), 1409–1418. https://doi.org/10.1111/1475-6773.13216

Fine, M. J., Ibrahim, S. A., & Thomas, S. B. (2005). The Role of Race and Genetics in Health Disparities Research. *American Journal of Public Health*, *95*(12), 2125–2128. https://doi.org/10.2105/AJPH.2005.076588

Giuntella, O. (2016). The Hispanic health paradox: New evidence from longitudinal data on second and third-generation birth outcomes. *SSM - Population Health*, *2*, 84–89. https://doi.org/10.1016/j.ssmph.2016.02.013

Gooding-Williams, R. (2024). W.E.B. Du Bois. In E. N. Zalta & U. Nodelman (Eds.), *The Stanford Encyclopedia of Philosophy* (Summer 2024). Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/archives/sum2024/entries/dubois/

Gresenz, C. R., Rogowski, J., & Escarce, J. J. (2009). Community Demographics and Access to Health Care among U.S. Hispanics. *Health Services Research*, *44*(5p1), 1542–1562. https://doi.org/10.1111/j.1475-6773.2009.00997.x

Gutting, G., & Oksala, J. (2022). Michel Foucault. In E. N. Zalta & U. Nodelman (Eds.), *The Stanford Encyclopedia of Philosophy* (Fall 2022). Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/archives/fall2022/entries/foucault/

Hadas, M. (2021). *Outlines of a Theory of Plural Habitus: Bourdieu Revisited*. Routledge. https://doi.org/10.4324/9781003179702

Hall, A. G. (1998). Medicaid's impact on access to and utilization of health care services among racial and ethnic minority children. *Journal of Urban Health*, *75*(4), 677–692. https://doi.org/10.1007/BF02344498

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *American Journal of Public Health*, *105*(12), e60–e76. https://doi.org/10.2105/AJPH.2015.302903

Hamilton, T. G., Palermo, T., & Green, T. L. (2015). Health Assimilation among Hispanic Immigrants in the United States: The Impact of Ignoring Arrival-cohort Effects. *Journal of Health and Social Behavior*, *56*(4), 460–477.

Hammersley, M. (2006). *<no title>*.

Hartman, M., Martin, A. B., Whittle, L., Catlin, A., & The National Health Expenditure Accounts Team. (2024). National Health Care Spending In 2022: Growth Similar To Prepandemic Rates: National health care spending growth in 2022 similar to prepandemic rates. *Health Affairs*, *43*(1), 6–17. https://doi.org/10.1377/hlthaff.2023.01360

Hispanic/Latino Health | Office of Minority Health. (n.d.). Retrieved November 7, 2024, from https://minorityhealth.hhs.gov/hispaniclatino-health

Hostinar, C. E. (2015). Recent developments in the study of social relationships, stress responses, and physical health. *Current Opinion in Psychology*, *5*, 90–95. https://doi.org/10.1016/j.copsyc.2015.05.004

Jones, W. A. (2006). Medicaid 101: History, Challenges, and Opportunities. *Ethnicity & Disease*, *16*, 52–53.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. Basic Books.

Kubota, R., & Lin, A. M. Y. (2009). *Race, Culture, and Identities in Second Language Education: Exploring Critically Engaged Practice*. Taylor & Francis Group. http://ebookcentral.proquest.com/lib/emory/detail.action?docID=432763

Lee, H., Fitzpatrick, J. J., & Baik, S.-Y. (2013). Why isn't evidence based practice improving health care for minorities in the United States? *Applied Nursing Research*, *26*(4), 263–268. https://doi.org/10.1016/j.apnr.2013.05.004

Lopez, L. N.-B., Ana Gonzalez-Barrera, Khadijah Edwards, Lauren Mora and Mark Hugo. (2021, November 4). 1. Half of U.S Latinos experienced some form of discrimination during the first year of the pandemic. *Pew Research Center*. https://www.pewresearch.org/race-and-ethnicity/2021/11/04/half-of-u-s-latinos-experienced-some-form-of-discrimination-during-the-first-year-of-the-pandemic/

Magaña, D. (2019). Cultural competence and metaphor in mental healthcare interactions: A linguistic perspective. *Patient Education and Counseling*, *102*(12), 2192–2198. https://doi.org/10.1016/j.pec.2019.06.010

Masters, R. K., Aron, L. Y., & Woolf, S. H. (2023). Life Expectancy Changes During the COVID-19 Pandemic, 2019–2021: Highly Racialized Deaths in Young and Middle Adulthood in the United States as Compared With Other High-Income Countries. *American Journal of Epidemiology*, *193*(1), 26. https://doi.org/10.1093/aje/kwad180

Moore, L. J., Casper, M., & Lemke, T. (2011). *Biopolitics: An Advanced Introduction*. NYU Press. https://muse.jhu.edu/pub/193/monograph/book/11107

Morcelle, M. (2025, January 27). *President Trump's Day One Actions Threaten Medicaid and the ACA*. National Health Law Program. https://healthlaw.org/president-trumps-day-one-actions-threaten-medicaid-and-the-aca/

Moslimani, M. H. L. and M. (2022, January 20). Latinos See U.S. as Better Than Place of Family's Ancestry for Opportunity, Raising Kids, Health Care Access. *Pew Research Center*. https://www.pewresearch.org/race-and-ethnicity/2022/01/20/latinos-see-u-s-as-better-than-place-of-familys-ancestry-for-opportunity-raising-kids-health-care-access/

Multi-morbidity: A patient perspective on navigating the health care system and everyday life. (n.d.). https://doi.org/10.1177/1742395317731607

Neville, H. A., Gallardo, M. E., & Sue, D. W. (Eds.). (2016). The Myth of Racial Color Blindness: Manifestations, Dynamics, and Impact. American Psychological Association. http://www.jstor.org/stable/j.ctv1chs008

Nickens, H. W. (1991). The health status of minority populations in the United States. *Western Journal of Medicine*, *155*(1), 27–32.

Ontology. (n.d.). Retrieved December 17, 2024, from https://warwick.ac.uk/fac/soc/ces/research/current/socialtheory/maps/ology/

Ortega, P., Felida, N., Avila, S., Conrad, S., & Dill, M. (2023). Language Profile of the US Physician Workforce: A Descriptive Study from a National Physician Survey. *Journal of General Internal Medicine*, *38*(4), 1098–1101. https://doi.org/10.1007/s11606-022-07938-y

Papanicolas, I., Woskie, L. R., & Jha, A. K. (2018). Health Care Spending in the United States and Other High-Income Countries. *JAMA*, *319*(10), 1024. https://doi.org/10.1001/jama.2018.1150

Paradox. (2025, February 5). https://dictionary.cambridge.org/us/dictionary/english/paradox

Passel, M. M. and J. S. (2024, September 27). What the data says about immigrants in the U.S. *Pew Research Center*. https://www.pewresearch.org/short-reads/2024/09/27/key-findings-about-us-immigrants/

Plaut, V. C., Thomas, K. M., Hurd, K., & Romano, C. A. (2018). Do Color Blindness and Multiculturalism Remedy or Foster Discrimination and Racism? *Current Directions in Psychological Science*, *27*(3), 200–206. https://doi.org/10.1177/0963721418766068

Quadagno, J. (2006). Doctors' Politics and the Red Menace. In J. Quadagno (Ed.), *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (p. 0). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195160390.003.0002

Ruiz, J. M., Hamann, H. A., Mehl, M. R., & O'Connor, M.-F. (2016). The Hispanic health paradox: From epidemiological phenomenon to contribution opportunities for psychological science. *Group Processes & Intergroup Relations*, *19*(4), 462–476. https://doi.org/10.1177/1368430216638540

Sand-Jecklin, K. (2007). The Impact of Medical Terminology on Readability of Patient Education Materials. *Journal of Community Health Nursing*, *24*(2), 119–129.

Smith, K. P., & Christakis, N. A. (2008). Social Networks and Health. *Annual Review of Sociology*, *34*, 405–429.

Social ontology. (n.d.). https://doi.org/10.1177/1463499606061731

Sohn, H. (2016). Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage over the Life-Course. *Population Research and Policy Review*, *36*(2), 181. https://doi.org/10.1007/s11113-016-9416-y

The Trump Administration's Immigration Enforcement Policy: What Hospitals and Health Care Providers Must Know for Their Patients, Staff, and Visitors. (2025, January 28). https://www.ebglaw.com/insights/publications/the-trump-administrations-immigration-enforcement-policy-what-hospitals-and-health-care-providers-must-know-for-their-patients-staff-and-visitors

Tolsdorf, C. C. (1976). Social Networks, Support, and Coping: An Exploratory Study. *Family Process*, *15*(4), 407–417. https://doi.org/10.1111/j.1545-5300.1976.00407.x

Warrier, L., Devika, M., Rajesh, N., Abhishek, S., & T, A. (2023). Bridging Medical Terminology: Enhancing Accessibility and Comprehension. *2023 3rd International Conference on Smart Generation Computing, Communication and Networking (SMART GENCON)*, 1–5. https://doi.org/10.1109/SMARTGENCON60755.2023.10441977

What are competencies? (2017, June 9). [Text]. https://hr.nih.gov/about/faq/working-nih/competencies/what-are-competencies

Wilson, A., & Childs, S. (2002). The relationship between consultation length, process and outcomes in general practice: A systematic review. *British Journal of General Practice*, *52*(485), 1012–1020.