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At a Loss for Words: Language Choice in the Doctor's Office

Evan Schloss

As we push on further into the 21st century, rising rates of immigration combined with increasing globalization have diminished the need for ethnic communities to assimilate into American culture. It is well established that there are significant disparities in health-care existing along ethnic and racial boundaries. Cultural and political pressures push communities to pick and choose which aspects of the native cultures to preserve in their new environment. Thus the differing cultures clash and the most apparent of these clashes is language. To function in society, individuals must communicate with others using language, creating a dynamic interplay between different languages. In this kind of situation, it is unclear when, where, and how each language takes precedence. The doctor-patient relationship is one of the closest interactions that exist, where the patient reveals his or her lifestyle, emotions, and personal views to the doctor, and the doctor reciprocates by using that information to comfort and heal. Of course, this is the epitome of the ideal doctor-patient relationship, and things are not so simple in practice. It is the *words* doctors and patients use to interact that are essential to the outcome. So the question is: how do we choose what words we say to others? And furthermore, how do those choices affect the other person's attitude toward the relationship?

Let us put aside the doctor-patient relationship for now, and examine language choice from a linguistic point of view. There can be many reasons why a person chooses to speak a certain way to another person. For example, a child may address an adult in a formal way to express the power disparity between them. Similarly, that child may speak more frankly using slang to one of his or her friends. Linguist Joan Rubin extensively mapped out the boundary between two endemic languages in a bilingual society when she investigated the use of Spanish and Guarani (a native language) in Paraguay.¹ Rubin aimed to expand upon earlier studies with a comprehensive look at *all* the factors that influenced language choice, including location, first language acquisition, and predicted language proficiency. The location of bilinguals (either rural village or urban city) greatly influenced their language choice of either Guarani or Spanish, as a result of assumptions and internal assertions about the likelihood of whether those they encounter would speak either language. This is in addition to how they judge the specific individuals they wish to speak with, and their backgrounds in each language (degree of bilingual-ness). In general, formal situations like talking to a teacher, a well-dressed stranger, or any stranger in a city would warrant a bilingual person to speak Spanish (as the language of the establishment), while any other situation with even a hint of informality would warrant a bilingual speaker to speak Guarani, the "common" language.

Indeed, this criterion is supported by others investigating this subject. Linguist Peter Farb writes of the Guarani speaker "quickly feeling his inferiority...coming to market in the city" and generalizes that "probably all bilingual situations equally stigmatize those who use low-prestige languages."² Thus the overarching influence that molds the "norms" determining language choice appears to be what opinions one has about either language, and how that choice will make him or her appear to others. Of course, this opinion depends on where and to whom the speaker is speaking, among other criteria.

How can such linguistic interactions shed insight on the doctor-patient relationship? It is exactly these covert calculations that determine the course of a medical interview. The doctor-patient relationship is primed to behave like interactions in a bilingual society because it is a power relationship. The doctor speaks two dialects, the vernacular and medical jargon, in either English, another language, or multiple languages, and the patient may speak multiple languages at varying proficiency with his or her own level of understanding of medicine, traditional or non-traditional.

The moment a patient steps through the door, a negotiation of these cultural norms begins. What race is the patient? How is the patient dressed? Does the patient speak with an accent? Content with his or her

impression of the patient, the doctor begins to speak to the patient. After several exchanges, the doctor may receive new signals and switch to a different speaking tone or level of vocabulary. Linguistically, this is called "code switching." Meanwhile, the patient may be completely different from doctor's assessment and speak very formally, holding back information because he or she is intimidated by the doctor. The patient may even be offended by the doctor's code switching mid-interview, based on the doctor's own cultural assumptions. By the end of the interview, the level of information obtained by the doctor and the patient's satisfaction can widely differ depending on the cultural negotiations during the clinical encounter.³

Language choice and cultural assumptions between doctor and patient have genuine effects. A study reported that residents viewed African Americans as less likely to abstain from substance abuse, less educated, less intelligent, and less likely to pursue a healthy lifestyle. This could translate into residents not considering African Americans as worth the effort to treat to the same standard as other groups. Another study found that Hispanic men received less analgesia compared to Caucasian men for the same amount of pain. Most striking, especially considering today's emphasis on empathy in medical education, is a study that reported Hispanic patients feeling less empathy and rapport building even when interviewed in English. Clearly there is some incongruity between what the patient conveys as his or her concerns and how the doctor interprets those concerns, resulting in unsatisfactory care and an unproductive doctor-patient relationship.⁴

This means that no matter how good an interviewer's interpersonal skills, no matter how they tried to convey empathy or cultural understanding, there was a fundamental disconnect between interviewer and patient. I don't think this was an active bias. Medical professionals do not choose where they grew up or what their cultural background is, and it can be difficult to relate to patients who speak differently and have a different background. Doctors and patients cannot just hand each other a written summary of their backgrounds and cultural views. Instead, they must gather this information during a brief clinical encounter, judge it against their own cultural assumptions, and decide to speak a certain way, all without flinching from their duties as doctor and patient.

It is no surprise that there are so many health-care disparities today. If there is always some cultural bias in doctor-patient interactions, then the only viable solution would seem to be matching patients and doctors based on ethnicity. Indeed, it has been shown that minority patients have expressed greater satisfaction and greater utilization of health-care services when their providers are of their own race.⁵ However, it is impossible for every patient to have a doctor of a race of his or her choosing. Perhaps health-care professionals could research as much as they can about cultural aspects of their patient's lives to lessen the burden of cultural negotiation during an interview. Professional interpreters should be used as much as possible to salvage patient information vulnerable to cultural misunderstandings. There can never be a perfect system where the doctor comes precisely from a patient's culture and speaks the same "language." Still, we can look to linguistics for a model of the dynamics of the doctor-patient cultural negotiation juggling act.

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