J Immigrant Minority Health (2018) 20:1–4
DOI 10.1007/s10903-017-0556-x

LETTER TO THE EDITOR

Reconceptulizing Language Discordance: Meanings and Experiences of Language Barriers in the U.S. and Taiwan

Elaine Hsieh[1]

Published online: 24 February 2017

Abstract Individuals with language barriers may face challenges unique to a host society. By examining and comparing the sociocultural conditions that can result in providers and patients not sharing the same language in the United States and in Taiwan, I argue that (a) language discordance is a social phenomenon that may entail diverging meanings and experiences in different countries; (b) language-discordant patients may not share similar experiences even if they are in the same country; and (c) disparities in language concordance may be confounded with other disparities and cultural particulars that are unique to a host society. In addition, because English is a dominant language in medicine, language-discordant patients' quality of care in Taiwan can be moderated by their fluency in English.

Keywords Language discordance · Cross-cultural care · Medical English

The literature on cross-cultural care has provided ample evidence on how linguistic and cultural differences can create barriers to patients' health experiences, including their access to and process of care [4, 8]. For over 20 years, my US-based research investigates how language-discordant patients, such as patients with English-limited proficiency (LEP), coordinate and negotiate healthcare services with their healthcare providers. As I presented my model of Bilingual Health Communication [4], a communicative model that aims to provide guidance for interpreter-mediated provider-patient interactions, I began to wonder if individuals' experiences of language barriers in healthcare settings are universally shared or may have unique elements that are specific to sociocultural and/or sociopolitical environments of a host society [9].

In 2015, I became a U.S. Fulbright Scholar and received funding for my research project, Quality of Care for Interpreter-Mediated Medical Encounters in Taiwan. Between July 2015 and January 2016, I conducted individual interviews and focus groups with over 35 research participants, including healthcare providers, immigrants, and healthcare interpreters (who are also immigrants) to explore the different challenges and barriers to care faced by language-discordant immigrants and workers in Taiwan. My experiences in Taiwan have challenged many beliefs that I have taken-for-granted. In particular, my research suggests that (a) language discordance is a social phenomenon that may entail diverging meanings and experiences in different countries; (b) language-discordant patients may not share similar experiences even if they are in the same country; and (c) disparities in language concordance may be confounded with other disparities and cultural particulars that are unique to a host society.

Different Experiences and Meanings of Language Discordance in the U.S. and Taiwan

The literature on immigrant and minority health in the United States has provided conclusive evidence that when patients do not share the same language with their providers, they experience significant health disparities at all stages of care [4]. They also often face stigmatization and prejudicial attitudes due to their outsider, minority status

✉ Elaine Hsieh
ehsieh@ou.edu

[1] Department of Communication, University of Oklahoma, 610 Elm Ave #101, Norman, OK 73019, USA

[7]. Consequently, when I first designed a study to investigate language-discordant patients in Taiwan, I was mostly concerned about the experiences of foreign workers and immigrants from Southeast Asian countries. There have been many studies about Southeast Asian immigrants and workers' experiences of social stigma in Taiwan [10].

Nevertheless, as I asked physicians, "What are the challenges you face when talking to language-discordant patients and how do you usually cope with these challenges?," I was surprised by their responses. "Do you mean how I treat elderly patients who only speak Taiwanese because I'm a second generation mainlander who only speaks Mandarin Chinese?" "Yeah, it's difficult to work with patients who only speak Taiwanese, Hakka, or aboriginal languages." Their responses jolted my understanding of language discordance as a social phenomenon in Taiwan.

My conceptualization of language-discordant patients has been shaped by the literature in the West. In the U.S., English is the dominant language. Thus, LEP patients in the U.S. are often conceptualized as outsiders, a particular type of cultural and linguistic minority. However, although Mandarin Chinese is the dominant language in Taiwan, it only became the official language after 1945 when the Republic of China (ROC) government took over Taiwan from the Japanese government after WWII. In 1949, the ROC government lost the Chinese Civil War and officially resettled in Taiwan after losing control of mainland China. During the period 1945–1950, roughly 2 million *wai sheng ren* (外省人, which literally means "outside province people") moved from mainland China to Taiwan, which had a population of 6.27 million at the time. Although wai sheng ren accounted for less than a quarter of the total population in Taiwan, the ROC government mandated Mandarin Chinese to be the official language for all governmental and educational settings. Thus, it became the language of all intellectuals and the dominant language in Taiwan. Nevertheless, Taiwanese and Hakka remain common, if not the primary, languages spoken by *ben sheng ren*[1] (本省人, which means "original province people") in everyday life in some regions to this day [11].

In summary, the phenomenon of language discordance is situated in the complex tensions of political power and linguistic legitimacy. Whereas an LEP patient in the U.S. can be viewed as an outsider, a Taiwanese- or Hakka-speaking patient in Taiwan is, in fact, a "local." In the case of a patient who speaks only Taiwanese, s/he is also a member of the ethnic *majority*. Nevertheless, the fact that the patient has limited Mandarin Chinese proficiency suggests other potential constraints and barriers to care (e.g., low health literacy and low socioeconomic status) as s/he is likely experience marginalization from the "mainstream" society (e.g., in governmental and educational settings). Few studies have examined how the tensions of being a member of the local and ethic majority and of a marginalized group in a society can shape these language-discordant patients' quality of care.

Not All Language-Discordant Patients Share the Same Experiences

Language-discordant patients may not share similar experiences even if they are in the same country. After recognizing the complexity of language discordance in Taiwan, I began to develop a more nuanced view about how language discordance can shape individuals' health experiences. For example, because English is the dominant language for medical education and healthcare settings in Taiwan[2] (e.g., medical textbooks are often in English, patients' medical records are kept in English, and prescriptions are also typically in English), all healthcare providers are able to communicate to English-speaking patients through written, if not spoken, English. For example, a Mandarin-speaking only physician can rely on medical English to identify symptoms and write down diagnosis and treatment for an English-speaking patient to facilitate his/her understanding of the illness. In other words, a blue-collar patient from the Philippines, which adopts English as one of its two official languages, is more likely to have better communication than a blue-collar patient from Thailand. In fact, a physician even argued that it's harder to explain certain diagnoses in Taiwanese, which does not have terms for the corresponding medical concepts, than in medical English. From this perspective, English-speaking patients in Taiwan are likely to have better quality of care and provider-patient interactions than other language-discordant patients.

It is important to recognize that physicians' English proficiency is primarily based on their medical training rather than a general proficiency in linguistic ability. As a result, the quality and success of a medical encounter may be dependent on a patient's ability to use and understand English in medical contexts. For example, a physician may ask if a patient experience "tremors" or "heart palpitations" but unable to explain the symptoms in more details in English.

[1] Traditionally, ben sheng ren refers to all ethnic groups, including Han Chinese, who reside in Taiwan prior to 1945. Wai sheng ren refers to individuals (and their children) who moved from China to Taiwan primarily between 1945 and 1950, when the ROC government lost control of mainland China and resettled in Taiwan.

[2] In early 2015, several legislators proposed to require medical records to be written in Chinese, but faced strong oppositions from many medical associations and healthcare practitioners. The legislation never made it to the floor [12].

As a result, it is important to recognize potential limitations even when providers and patients can communicate through medical English.

Cultural Particulars for Disparities in Language Concordance

Disparities in language concordance may be confounded with other disparities and cultural particulars that are unique to a host society. In Asia, one's English proficiency is often tied to his/her education level. In addition, not all language-discordant workers from foreign countries are of equal footing in Taiwan. The laws in Taiwan created two categories of foreign workers: blue-collar and white-collar workers. Blue-collar workers are mostly from Southeast Asian countries. (e.g., Indonesia, Thailand, and Vietnam, among others). They generally are workers of intensive labor and domestic caregiving with lesser education. In contrast, white-collar workers are often from developed countries such as the U.S. and Japan. They typically are skilled experts, holding positions as technicians, managers, or educators. As a result, these patients are likely to have higher health literacy and socioeconomic status than blue-collar workers, and thus, enjoy better health outcomes. In addition, because white-collar workers' higher level of education, they are also more likely to be able to speak English, and thus, ensure better quality of communication with their providers in Taiwan.

One unique and unexpected finding about the quality of care for immigrant workers in Taiwan is the impact of National Health Insurance (NHI), a universal insurance for all citizens and foreign workers with residence permits [6]. Unlike my research participants in the U.S., few participants in Taiwan can recall incidents of prejudice in healthcare settings despite well-documented social stigma in the larger society [10]. In fact, several participants argued that the lack of such incidents is a result of the NHI as all patients share the same reimbursement rates. In fact, because immigrants often seek information about healthcare services through their social networks [1], several hospitals in Taiwan view foreign workers as a niche market with great revenue potential. As a result, the NHI in Taiwan significantly minimizes language-discordant patients' experiences of inequality and problematic care.

Reconceptulizing Language Discordance in Healthcare Settings

With these new insights, there are three interesting twists to the phenomenon of language-discordance in Taiwan. First, the quality of care for language-discordant patients is likely to be mediated by their abilities to speak English and moderated by other factors. I suspect that this phenomenon is not limited to Taiwan. After all, due to the West's dominance in medicine and technology, health care providers often need to be fluent in English to keep up with the latest medical breakthroughs and treatment recommendations. Whereas the current literature in the West has centered on patients' language concordance status within a host society to define their health experiences, my experiences in Taiwan suggest that a language-discordant patient with some level of English proficiency is likely to secure better provider-patient communication than other language-discordant patients.

In addition, not all language-discordant patients face the same challenges. Some may experience greater challenges due disparities in other areas (e.g., education level and socioeconomic status). It would be inappropriate to assume that a Japanese-speaking white-collar worker and an Indonesian-speaking blue-collar domestic care worker face similar challenges or require similar assistances when accessing healthcare services in Taiwan. Similarly, a Taiwanese-speaking elderly may have greater difficulties to communicate with a Mandarin Chinese-speaking physician than a white-collar worker from the United States. Compared to foreign workers who have access to the NHI, foreign nationals who are ineligible to join the NHI (e.g., undocumented workers or individuals without residence permit)[3] may face additional challenges in addition to language barriers when accessing healthcare services.

Second, it may be important to consider sociocultural and sociopolitical factors of a particular society in conceptualizing language-discordant patients' care. An under-theorized and under-synthesized area of research on LEP patients is the various factors that may serve as mediating and moderating factors for language-discordant patients' experiences in healthcare settings. For example, when thinking about LEP patients, one's mind typically gravitates towards Spanish-speaking Latino patients rather than Russian-speaking Caucasian patients. This may be because immigrants from Mexico account for a large percentage of LEP patients in the U.S. As a result, more infrastructures may be provided to Spanish-speaking patients than Russian-speaking patients in the U.S.

[3] During my research period in Taiwan, I was able to obtain immediate eligibility for the NHI as a Fulbright Scholar. However, my husband was not able to join the NHI because an accompanying spouse is not eligible in the first 6 months in Taiwan.

In contrast, when talking to my research participants in Taiwan, white privilege emerged as an important issue. Because white privilege[4] is a prevalent ideology in Asia due its sociohistorical and sociopolitical contexts [5], skin color can be an important factor in shaping language-discordant patients' experiences. For example, a physician may be more accommodating and responsive to the needs of a Caucasian patient than a dark-skin Asian. In addition, skin color is often confounded with other social determinants of health in Taiwan. For example, aboriginals in Taiwan often have darker skin, lower education level, and low socioeconomic status. Caucasian immigrants in Taiwan are more likely to be white-collar workers than blue-collar workers. Such correlations, as reflected in normative attitudes and beliefs, can result in disparities in healthcare delivery for different groups of language-discordant patients.

Finally, ensuring the quality of communication for language-discordant individuals is essential to ensure the quality of care for these individuals as well as the people they care for. Many providers commented that it is becoming increasingly common for the foreign workers, who work as domestic caregivers, to bring the elderly whom they care for to healthcare settings. They (as opposed to the patients' children) are the ones that provide details about the patient to ensure an accurate diagnosis and appropriate treatments. The literature has suggested that a parent's LEP status is an important indicator to a child's quality of care and health outcomes [2]. Following the same logic, as Taiwan increasingly relies on foreign workers to engage in caregiving work for the elderly and the weak (e.g., individuals with disabilities, including children) in response to their aging population, providing language access to language-discordant individuals at healthcare settings is critical to ensure the quality of care for all, especially for the marginalized.

Compliance with Ethical Standards

Conflict of interests The author reports no conflicts of interests. The study has been approved by the Institutional Review Board at The University of Oklahoma.

Ethical Approval The study has been approved by the Institutional Review Board at The University of Oklahoma.

Informed Consent All participants have offered informed consent prior to participating in the author's Fulbright study.

References

1. Caidi N, Allard D, Quirke L. Information practices of immigrants. Ann Rev Inf Sci Technol. 2010;44:491–531.
2. Flores G, Abreu M, Tomany-Korman SC. Limited English proficiency, primary language at home, and disparities in children's health care: how language barriers are measured matters. Public Health Rep. 2005;120:418–30.
3. Glenn EN. Yearning for lightness: transnational circuits in the marketing and consumption of skin lighteners. Gender Soc. 2008;22:281–302.
4. Hsieh E. Bilingual health communication: working with interpreters in cross-cultural care. New York: Routledge; 2016.
5. Isa M, Kramer EM. Adopting the Causasian "look": reorganizing the minority face. In: Kramer EM, editor. The emerging monoculture: assimilation and the "model minority". Westport: Praeger; 2003. p. 41–74.
6. National Health Insurance Administration. (2016). FAQs. http://www.nhi.gov.tw.
7. Steinberg EM, Valenzuela-Araujo D, Zickafoose JS, Kieffer E, DeCamp LR. The "Battle" of managing language barriers in health care. Clin Pediatr. 2016;55:1318–27.
8. Terui S. Conceptualizing the pathways and processes between language barriers and health disparities: review, synthesis, and extension. J Immigr Minor Health. 2015. doi:10.1007/s10903-015-0322-x.
9. Terui S. *Cross-cultural comparisons on pathways between language barriers and health disparities*. Ph.D. (Doctoral Dissertation). (2016). Retrieved from SHAREOK database.
10. 楊婉瑩, & 張雅雯. (2014). 為什麼反對移工/移民?-利益衝突抑或文化排斥. *政治科學論叢*, 43-84.
11. 洪惟仁. (2002). 台灣的語言政策何去何從. Retrieved August 3, 2016, from http://mail.tku.edu.tw/cfshih/ln/paper18.htm.
12. 舒子榕, 魏怡嘉, & 呂素麗. (2015, January 22). 反彈聲浪大 病歷中文化別提了, *中時電子報*. Retrieved from http://www.chinatimes.com/newspapers/20150122000491-260114.

[4] White privilege as a cultural phenomenon in Asia can be reflected in different ways. For example, many women in Taiwan engage in health practices (e.g., getting skin-lightening injections and using "whitening" skincare products) to maintain a light-skin complexion [3].