

Pursuing Testimonial Justice: Language Access through Patient-centered Outcomes Research with Spanish Speakers

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Patient-Centered Outcomes Research (PCOR), rooted in the more established tradition of Community-Based Participatory Research (Deeb-Sossa 2019), seeks to empower patients in determining the most appropriate healthcare options by including and amplifying their voices in every aspect of the research process. In this article, we report on the outcomes of a four-year PCOR engagement effort in the US Midwest that aimed to include and amplify patient voices in language in healthcare policy. Our findings revealed feelings of patient disempowerment, discomfort with the social distance created by remote interpreting, and a mismatch of knowledge and expectations among interlocutors in medical interactions. Our discussions also underscored women's work in addressing healthcare issues within the family and their resilience in describing systemic inequities in health communication. We argue that participation in PCOR empowers patients through the enactment of testimonial justice. We conclude by discussing implications and recommendations for language researchers who are interested in working toward social justice in language in healthcare policy in USA and building a multi-stakeholder platform for PCOR.

1. INTRODUCTION

Health disparities have been an intractable social justice concern among Spanish-speaking communities in USA. From the tuberculosis epidemics in the 1920s to the current COVID-19 (coronavirus) pandemic, Spanish speakers have experienced disproportionate infection, morbidity, and mortality rates (Trevizo 2020). Chronic disease also disproportionately affects Spanish speakers leading to excessive mortality rates and decreased quality of life (Mendenhall 2016). These health inequities stem from a historical minoritization of Spanish speakers that positions them according to their limitations

rather than their strengths (e.g. referring to patients', 'Limited English Proficiency', and 'having' language barriers). In addition to ideological and policy issues, quality healthcare for minoritized groups also depends on healthcare providers' willingness to consider perspectives, experiences, systems of knowledge, and expectations that may differ from prevalent biomedical views on professionalism and health. Medina (2013: 27) argues that 'social injustice breeds epistemic injustice by weakening epistemic relationships between marginalized social groups—unfairly depicted as intellectually inferior and lacking credibility—and their epistemically privileged counterparts'.

Social justice for minoritized language speakers involves tearing down barriers to vital institutions and social services and also 'broadening our linguistic imagination to acknowledge that everyone has the right to be heard and to be listened to' (Piller 2016: 162). Testimonial justice—the individual's right to be heard and believed without prejudice or stereotype (Fricker 2007)—is key to addressing social justice for Spanish speakers. It is about opening up spaces for expression and listening attentively within those spaces (Medina 2013). Social justice work has taken different forms to address health disparities affecting minoritized language speakers. Efforts to promote health and educate Spanish-speaking populations emerged in the early 20th century (Martínez 2013). Direct confrontation of discriminatory practices in healthcare, including coerced sterilization, surfaced at the close of the century. Notwithstanding these advances, Spanish-speaking patients' engagement in the Latino health research agenda has been a blind spot in the march toward social justice for their communities, even with an increasing focus on patient-centered research in public health.

The silencing of Spanish-speaking voices in Latino health research is a serious social justice concern that can be uniquely addressed from an applied linguistics perspective. Language is implicated not only in the constitution and maintenance of healthcare inequity but also in its contestation and remedy (Avineri *et al.*, 2018). Testimony is a concrete way in which language remedies existing injustices. The concept of *testimonio* in Spanish-speaking communities, however, suggests a more specific meaning. The Latina Feminist Group defines *testimonio* as 'a form of expression that comes out of intense repression or struggle . . . [as an] effort by the disenfranchised to assert themselves as political subjects through others, often outsiders, and in the process to emphasize particular aspects of their collective identity' (cited in Deeb-Sossa 2019: 208). Testimonial justice, thus, involves carving out spaces for self-assertion and collective identity building. Inequities occur when conversations about public health problems exclude the voices of certain individuals because their voices are not perceived as valuable or valid; similarly, inequitable care occurs when certain individuals are not able to share their own observations, experiences, and perspectives with those providing care (Briggs and Mantini-Briggs 2016). Inability to communicate in the dominant language is one of many characteristics that might lead health authorities to exclude voices of those affected by

health inequities, thereby exacerbating inequities. Individuals experiencing inequities should be the ones to determine what ‘communicative justice’ will look like in their particular context (Briggs and Mantini-Briggs 2016).

While traditional approaches to research are centered on the role of academic scholars in study design, data collection, and analysis, we recognize that testimonial justice requires engaging community voices throughout the research process. Community-Based Participatory Research (CBPR) and Patient-Centered Outcomes Research (PCOR) are methodological approaches that emphasize the application of testimonial justice in the research process. Minkler and Wallerstein (2008) describe CBPR as a participatory, cooperative, and co-learning process. It offers participants a sense of ownership in research activities and fosters a sense of comfort between study participants and researchers within a framework of *convivencia* or shared awareness of mutual humanity (Delgado Bernal *et al.* 2019). PCOR takes the principles of CBPR and applies them specifically to biomedical research with a focus on involving patients and other stakeholders as equitable partners in every phase of the research project. In this article, we report on our process of stakeholder engagement in an early phase of PCOR in which we built a team of stakeholders and developed an understanding of the experiences and problems that were important to them.

2. METHODS

Established in 2016, our PCOR/CBPR team comprised a range of stakeholders, including clinicians, interpreters, patients, and family members who met on an ongoing basis to develop and advance research questions to improve language access. Our engagement approach can be described as multifaceted and nonlinear. It was multifaceted in that we engaged stakeholders in holistic terms rather than in narrow, research-oriented terms, leading to the emergence of multiple activities beyond the formulation of research questions: support groups, connecting group members to community resources, and identifying internal strengths to meet challenges. It was nonlinear in that participants were encouraged to bear witness to their struggles with language access and to reflect on these experiences in the context of others’ similar experiences. Research questions were thus collaboratively formed and always open to revision.

The conversations referenced in this article consisted of meetings with patients and family members involved in previous PCOR team meetings between 2016 and 2019 at four engagement sites in Ohio: Cincinnati, Columbus, Toledo, and Lorain. In 2019, a regional lead at each engagement site invited patients and family members who had previously been involved in PCOR team meetings to meet with us. At each site, we met in community health/social service centers for 60–90 min. Following introductions and a brief overview, we asked additional questions leading to wide-ranging discussions drawing on past healthcare system experiences. Rather than collecting

Table 1: Focus group participant demographics

City	Ethnicity	Women	Men
Cincinnati	Ecuadorian, Mexican	5	2
Columbus	Mexican	3	1
Lorain	Puerto Rican, Mexican	7	3
Toledo	Mexican	13	8
Total		28	14

‘data’ for analysis, we view these conversations as a process of team building, the development of a shared understanding of stakeholder experiences and community needs and opportunities, and stakeholder empowerment (Deeb-Sossa 2019).

As Table 1 shows, we primarily (and unintentionally) engaged Spanish-speaking Latinas in our focus groups; therefore, their voices shape the findings presented here. We transcribed each of the conversations and each co-author reviewed the transcripts to identify salient themes. The list of themes was compared among the co-authors and interpreted in light of our collective understanding of health disparities through the theoretical framework of testimonial justice (Pavlenko 2007). We highlight specific insights that emerged organically from our participants in four thematic areas, engaging theoretical perspectives in applied linguistics to frame issues raised by our stakeholders through a social justice lens. The following themes were addressed more than once in at least two engagement sites: (i) gender issues; (ii) socio-cultural issues; (iii) remote and in-person interpreting; and (iv) health literacy. These themes uncover social injustices. Through a focus on gender, we can glean the important, yet often invisible, labor of Spanish-speaking Latinas. Centering their voices reveals social prejudice in healthcare. This includes providers misjudging patients’ credibility and patients feeling silenced, the challenges of interpreting modalities and providing equitable language access, and the overlooked privilege of basic health literacy that serves to place blame on Spanish-speakers.

2.1 Listening to Latina voices

Testimonial *injustice* jeopardizes efforts toward creating more inclusive socio-cultural representation in healthcare (Gallagher et al. 2020). Enactment of testimonial justice offers insights into a data set like ours, where Latina participants predominate. According to Fricker (2007), gender is a social identity that influences how much credibility is given to people’s claims. In addition to these stereotypes associated with women, Latinas might also be affected by

the cultural construct of *marianismo* that portrays Latinas as passive or submissive and derives from the traditional ideal of the Virgin Mary. Descriptions of *marianismo* indicate that Latinas will 'suffer in silence', have a 'lack of agency or voice', and be 'timid' (Asencio 2012). However, through their testimonies, the Latinas in our group challenged the concept of *marianismo* and claimed agency through participation and knowledge-sharing.

To enact testimonial justice, while being mindful of epistemic injustices inflicted on women. We tried to establish trust by speaking Spanish, describing our professional experiences, promoting awareness about language barriers in healthcare, and seeking ways to help overcome them. We demonstrated our cultural competence in various ways, including recognizing the importance of family (e.g. by allowing participants to bring their children). When appropriate, we also self-disclosed (e.g. one member shared about her Spanish monolingual mother's own barriers in healthcare) as a strategy to bridge perceived social distance. This inviting atmosphere may have encouraged these women to voice their concerns and reveal their resilience.

We found that gender and cultural norms affect communication barriers in healthcare, but not in ways that past research might suggest. The women in our study challenged the concept of *marianismo* in several ways. First, women outnumbered men 2:1. They voiced their issues and claimed agency as participants. Second, during meetings, women spoke proportionately more than men; while women represented 66 per cent of participants, they spoke 82 per cent of the time. This pattern was consistent with previous PCOR team meetings.

Men's low participation in the group conversations uncovers an insight into the ecology of health communication in Spanish-speaking families. Our team unsuccessfully encouraged the men to speak about their experiences (they were generally reluctant to share experiences) and those who did, did not report communication issues. Some said that their wives or children dealt with all communication aspects of healthcare. When asked whether participants had other problems with language access, a man responded, '*problema? No.*' His wife, sitting next to him, laughed. She explained, '*porque yo soy la que me entiendo con todo lo de él*' (because I am the one who deals with all his issues). This quote underscores the struggles the healthcare system generates for Spanish speakers. Women are not epistemic or testimonial subjects, but they consistently claim agency by assuming communication roles (Madriz 1998).

In one case, a man acknowledged that although he spoke English better than his wife, he still relied on her. Women described their role of communicating with healthcare providers as a very stressful process. For example, an older Puerto Rican woman shared how she did not speak English, and it took her 3 hours to obtain medication for her husband. Because her husband's healthcare providers had miscommunicated with the pharmacy, he missed taking one of his medications (Lorain, OH).

In terms of ecological organization, participants agreed that women are acknowledged and respected for their communication work in their families.

In Latino households, men speak to their wives about health concerns because women are seen as possessing more health knowledge, and their role is often to encourage and accompany men to their visits (Sobralnske 2006). These findings also bring to light the healthcare labor attributed to Latinas. While literature is scarce on Latina contributions when communicating on behalf of their spouses in healthcare settings, their roles may explain why participants were open to sharing their health stories. They showed resilience, bravery, and strength and were not passive victims. Latinas openly discussed their vulnerabilities in healthcare experiences, and their stories empowered others in the group as they built on each other's experiences. Language barriers cause them stress, but that does not make them passive as the concept of *marianismo* would indicate.

2.2 Sociocultural issues

In our conversations with these Spanish-speaking women, we found a salient sense of displacement and marginalization. The *testimonios* of our participants, who shared their feeling of being undermined in their capacity as knowers and as givers of knowledge owing to language and identity biases, illustrate the biased processes that emerge in the biomedical contact zone (cf. Pratt 1993). Prejudices, underpinning the practice of testimonial injustice, can accord a 'credibility deficit' (Fricker 2007: 17) to the patient's words or testimony and impair their ability to convey reliable information about their health or that of their family members. Biased views by health providers of insufficient knowledge of English or patient identities occurred frequently in our conversations. When discussing quality of healthcare, as shown in Table 2, one woman shared the perception that her child's psychiatrist was not attentive and did not ask her in-depth questions about her daughter's condition, during the clinical encounter, because she was Latina.

These biased presumptions grounded on discriminatory views of the Spanish-speaking patient-as-lesser because of difference in language or (mis)-judgment of patient intelligence can result in relationship breakdowns as the patient feels epistemically excluded and suffers a loss of testimonial authority (Briggs and Mantini-Briggs 2016). One instance of credibility deficit was bravely shared by a patient coerced by her interpreter into changing her own pain level, as seen in Table 3.

Table 2: Transcript—Participant from Lorain, OH

Muchas veces, simplemente te ven como que no eres de aquí. ¿Me entiende? Sí te atienden, pero no es lo mismo; piensan que tú a lo mejor no eres tan inteligente ...	Many times, they see you simply as someone who is not from here. Right? Yes, they care for you but it's not the same; they think that maybe you're not that smart ...
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Table 3: Transcript—Participant from Toledo, OH

Y yo le decía a ella, pues, es que me duele el diez y ella: no, no, no te duele el diez, porque si te doliera el diez... te duele como el ocho. Bueno, me duele el ocho	And I was telling her, well, my pain is a ten and she said [interpreter]: no, no, no it is not a ten, because if it were a ten ... it is like an eight. [Patient] Okay then, it is an eight
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Table 4: Transcript—Participants from Toledo, OH

Sí, porque a mí me ponen puros hombres y luego me da pena decirles	Yes, because they assign only men to me and then I am embarrassed to tell them.
Te da vergüenza; a mí así me pasó también	You are embarrassed; the same thing happened to me.
Me han tocado puros hombres, también doctores; doctoras casi no me tocan y después da pena decirles a veces si uno tiene el dolor fuerte	They have assigned only men to me, male doctors; hardly any female doctors, and then you feel embarrassed sometimes to tell them if one has a strong pain

A 0–10 pain scale (where 0 indicates no pain and 10 is the worst pain possible) is a common symptom elicitation technique, but it is restrictive because aspects of the pain experience cannot be gauged from such a scale (Bullo 2020). It also fails to account for different cultural narratives of the pain experience or how pain is conceptualized across cultures (Sullivan 1995). In this example, the participant’s testimony provides insights into how the biomedical perspective is prioritized and how her agency is compromised, even with the support of an interpreter.

Suppressing and even silencing their own speech appear to be common discursive practices shared by participants facing fear or intimidation during their medical encounters. Patients shared feelings of intimidation when having to speak about certain medical topics with opposite gender healthcare professionals. As seen in Table 4, two women expressed their difficulty in speaking to their gynecologist during a pap test, because they felt embarrassed.

Other patients described their reticence to ask or share intimate details of their lives with their mental healthcare providers, as seen in Table 5.

Feelings of intimidation in communicative situations with language discordant health care providers often lead to silence or to the withholding of language. During our interviews in Toledo, most of the focus group participants indicated that they withheld their questions despite not understanding what their doctors were saying to them, as seen in Table 6.

We also found a pattern of self-censorship when patients felt that interpreters were not friendly or receptive. They were afraid that if they spoke too much the interpreter would become angry with them, as seen in Table 7.

Table 5: Transcript—Participants from Toledo, OH

Si la mandan con un hombre, pues no se va a sentir con confianza	If they assign a man to you well, you are not going to feel trust
¿Cómo te vas a sentir con confianza de decirles las preguntas tan íntimas?	How can you feel trust to ask them such intimate questions?
[Uno] no se siente bien, no se siente bien.	[One] doesn't feel right, doesn't feel right

Table 6: Transcript—Toledo, OH

Interviewer:	¿Han tenido una experiencia en donde en realidad no entendieron, pero solo dijeron que sí para que fuera más fácil y se acabara la cosa? Puedes levantar la mano si hubo una experiencia en el médico que no entendiste pero dijiste nada más que sí.	Have you ever had a situation where you actually did not understand, but you said yes so that it would be easier, and the situation would end? You can raise your hand if there was a time at the doctor's office when you did not understand but just responded simply yes.
Participant 1:	Casi siempre.	Almost always.
Participant 2:	Ok, ok, y ya	Ok, ok, and that's it
Participant 3:	Creo que la mayoría siempre hemos hecho esto simplemente.	I think most of us have always simply done that.
Interviewer:	¿Porque te rindes?	Because you give up?
Patient 4:	Sí [...]	Yes [...]
Patient 5:	Yo tengo un cardiólogo, pero tampoco lo visito porque habla puro inglés y a veces está la persona que ayuda a interpretarte, pero a veces no y, pues como dice ella, nada más que ok ok, pero nos vamos sin saber nada de lo que nos dijo	I have a cardiologist, but I don't see him either because he only speaks English, and sometimes the person who helps interpret is there, but sometimes [he] isn't, and well, as she is saying, it's just ok ok, but we leave without knowing anything about what they told us.

In some cases, testimonies were excluded completely from epistemic consideration because they were judged irrelevant and subordinated to their authority, but patients did not always allow themselves to be silenced, instead demanding testimonial justice (Briggs and Mantini-Briggs 2016). When a Latina mother brought her ill daughter into the pediatric hospital for the third time after being sent home twice previously with a diagnosis of the flu, the healthcare provider attempted to send her home again without running tests,

Table 7: Transcript (Participant—Cincinnati, OH)

Si yo encuentro un intérprete más jovial que hable, pues yo me voy a sentir en más confianza ¿no? y si yo me encuentro con una persona seria, pues me voy a bloquear un poco. Quizá no me dé la facilidad de explicarle bien. Si le hablo mucho, creo que se va a enojar más	If I find an interpreter who is more cheerful who talks, well, I am going to feel like there is more familiarity, no? And if I find myself with a more serious person, I am going to feel a little more mentally blocked. Maybe I won't feel able to explain things to him well. If I speak too much, I think that maybe he will get angrier
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Table 8: Transcript—Participant from Cincinnati, OH

La última vez, pues, mi hija estuvo muy mal porque ella se me quedó en su cama. Ya no se me quería mover, y entonces allí fue cuando me dijeron que la llevara de nuevo a la casa (una cosa es contarles y otra es estar allí y pasar por esta situación), y allí yo les dije que no, y allí fue cuando llegaron como unos 5 enfermeras y doctores, y yo les dije que no, porque si le pasaba algo a mi hija yo les iba a denunciar	The last time, well, my daughter was in a real bad state because she stayed in her bed. She didn't want to move anymore, and then it was when they told me to take her back home again (one thing is to tell you about this and another is to be there and go through this situation), and there I told them no, and that is when around 5 nurses and doctors arrived, and I told them no, because if something happened to my daughter I was going to sue them
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even though the mother repeatedly insisted that the child's condition had worsened significantly. Frustrated and angry, the mother threatened to sue if they did not properly examine her child, who, in the end, was found to suffer from pneumonia (see [Table 8](#)).

Through the strength and courage that the mother demonstrated in her advocacy for her child, challenging conventional notions of Latina submissiveness, she established epistemic credibility and obtained the appropriate healthcare for her daughter.

2.3 Remote interpreting

Testimonios additionally demonstrate issues surrounding interpretation modalities. Remote modalities of interpreting through telephonic or videoconferencing platforms have been utilized in healthcare settings for many years and today are becoming ubiquitous. Research shows little difference between remote and face-to-face modalities in terms of accuracy and completeness of language mediation, even though interpreters and providers prefer the face-to-face modality for interpersonal aspects of communication ([Braun 2015](#)). [Anglelli \(2020\)](#) raises broader questions about how the interpreter shapes the relationship framework for patient-centered communication regardless of

Table 9: Transcript (participant and interviewer—Lorain, OH)

Porque yo le estaba diciendo que tenía un dolor aquí y él decía no ella está diciendo que abajo. Y no, yo lo tengo arriba y ahí mi hermano habló	Because I was telling him that I had pain here and then he said no she is saying that [it is] down low. And no, I have pain up above and then my brother spoke up
[...]	
Estaba señalando ¿verdad?	You were signaling, right?
Sí, es mejor en persona	Yes, it is better in person

modality. These concerns were evident in our conversations. Participants expressed that remote interpreters limited the conveying of emotions and made it difficult for interpreters to convey information from other conversations in the room. This modality also limited the negotiation of meaning and patients’ abilities to hear what remote interpreters were saying. Patients in our conversations never referred to remote interpreters as people. Instead, they used the term *la máquina* (‘the machine’) to refer to an audio or video remote interpreting system.

Participants described difficulties they experienced with communicating through body language when using remote interpreting services, as seen in Table 9.

Here, the patient explains that her body language did not convey her message to her healthcare provider about where she felt pain, so her brother had to help clarify. She concluded that interpreting is better in person. The situation demonstrates how even simple messages can be distorted through the use of remote interpreting.

Latina patients also described their feelings about interpersonal communication with remote and in-person interpreters, often suggesting that remote interpreting limited possibilities for the more personal aspects of interaction. ‘*Uno puede intercambiar algo más, aportar algo más, con el intérprete, y con una máquina no se puede.*’ ‘One can exchange something more, contribute something more, with the interpreter, and with a machine it can’t be done’ (Cincinnati, OH). This patient refers to the possibility of having an interpersonal communication with an in-person interpreter. The ‘patient-provider alliance’ may be influenced both by the act of language mediation and the use of different interpreting modalities.

2.4 Competence and health literacy

Finally, our participants described a tension between provider-side competency and patient-side literacy. Medical competencies include patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice

(ACGME 2017). In contrast, health literacy is often used to describe patients. Health literacy is a complicated construct involving individual, societal, and systemic factors situated in social practice. Patients' low health literacy, or limited capacity for basic health communication and services can create a barrier to providing quality healthcare (NIH n.d.); however, despite its recognized importance, the burden of health literacy is generally placed on patients rather than on providers. Consequently, patients' low literacy is seen as 'deficient', even though providers may also lack crucial knowledge about patients and their health care. Participants' experiences illustrate this dialogical relationship between competence (healthcare-personnel knowledge) and health literacy (patient knowledge).

Two concepts, schemas and frames, aided us when processing this insight. Tannen and Wallat (1987) describe schemas as 'expectations' in interactions. These differing expectations between doctors and patients have been described as the voice of medicine versus the voice of the life world (Marshall 1988) and epistemic divergence (Raymond 2014). Divergent knowledge schemas help explain the mismatch of understanding in medical interactions. According to Goffman (1981), a frame defines a situation or social activity a person creates. Shifting frames provide a basis for understanding talk, and frame incongruity can create misunderstanding.

Building on prior examples, the primary issue related to competence was the lack of providers who speak Spanish; participants framed interpretation as 'a lottery'. In addition, Latinas identified systemic barriers and linguistic obstacles, referring to repeatedly being passed back and forth when trying to obtain information likening their experiences to that of *la bolita del pimpón de un lado a otro* 'a ping-pong ball, back and forth' (Lorain, OH). They also emphasized times when they felt silenced by providers and interpreters. *No puede uno decirles alguna cosa porque se enojan* 'one can't tell them [interpreters] anything because they get angry' (Toledo, OH). They perceived a lack of competence on the part of providers specifically when there was a mismatch in schemas: *En el Ecuador cuando yo iba al Seguro era muy diferente, a mi hija me la tocaban, me la examinaban, y aquí no. Aquí me dicen tu hija está bien*. 'In Ecuador, when I went to the Seguro [public health system], it was very different, they would touch my daughter, they would examine her for me, and here they don't. Here they tell me, your daughter is fine' (Cincinnati, OH).

Health literacy is commonly viewed as a problem on the patients' side. But participants explained how they attempt to compensate for language issues by trying to learn English, asking to rephrase, not showing up, or giving up, rather than explaining to someone who would not listen. Latinas described doing the best they could with limited information, and their comments indicate a frame of agency (or involvement) in their own healthcare. They also described how they complained, refused care, or took family members along as linguistic brokers and advocates. They validated an aspect of their health literacy through flexibility and patience with the health care system.

An applied linguistics analysis can, therefore, flip the perspective, reframing competence, and health literacy. Patients view healthcare personnel as lacking competence because providers do not have access to Spanish language abilities and cannot understand patients' illness experiences. In contrast, examples throughout this article, demonstrate how patients see themselves as not having even the possibility of access to health information due to gender, socio-cultural, interpretation, and systemic barriers. For patients, language is social interaction, not just a tool to translate a message. This reality is important because patients are more likely to find information from sources where they already have a relationship.

Whereas physicians frame education as a means to patient health literacy, Latinas frame insight into the illness experience as necessary for provider competence. Ultimately, both health education and effective Spanish-language communication may result in patient competence (health literacy) and provider health literacy (illness understanding).

3. CONCLUSION

In this article, we examined salient themes that emerged from our engagement activities with Spanish-speaking patients and their family members in Ohio and identified several productive areas where applied linguists can collaborate with public health researchers to contribute to CBPR/PCOR with Spanish-speaking communities. We are in a unique position to draw on our experience engaging the voices of minoritized language speakers and examining inequities in the organization of communication structures. As applied linguists, we contribute theory and methods for understanding how speakers from diverse cultural and linguistic backgrounds negotiate intersubjectivity (Feuerherm *et al.* 2021). CBPR supports the applied linguistics mission of addressing 'language-related issues that affect individuals and society' (<https://www.aal.org/our-mission>) by responding to linguistic injustices as described by the individuals experiencing those injustices. Instead of simply analyzing what happens in interaction, our work approaches an 'emic' (or insider) perspective and can help us to determine future directions for applied linguistic research (Feuerherm *et al.* 2021). Applied linguistics informs our approach to the intersection of language and health. Our analysis of contact zones revealed that they are dangerous territories for minoritized groups because they are sites for the potential entrenchment of social injustice and inequity. However, they can also be understood as territory of positive social bonds when 'borders are placed in effect at the center of concern while homogenous centers move to the margins' (Pratt 1993: 88). Virtuous epistemic and communicative conduct can occur in the medical encounter if healthcare professionals recognize their own agentive roles in creating epistemic justice by modeling cultural humility's principles. These principles demand that healthcare providers be lifelong learners by stepping outside of their own linguistic

and cultural reference systems through continuous self-reflective examination of their biases and prejudices (Tervalon and Murray Garcia, 1998: 118).

Applied linguists also play a crucial role in observing the communication-related invisible labor of minoritized language speakers. Our approach allowed us to *listen* to the communities' testimonies and see the invisible labor Latinas are doing. Suggestions for supporting this community should include raising awareness of the harm of testimonial injustice, recognizing Latinas' labor, and displacing some of the communication-related burdens. What would the future of Latino healthcare be if Spanish speakers were listened to more closely, if their claims were taken more seriously, and if they were given all the credibility afforded to more privileged groups? For example, we see this playing out the organization *Alce su voz* ('Speak out', led by co-author Showstack in Wichita, Kansas), empowers Spanish-speaking Kansans to share their healthcare experiences, and calls to action with policy makers. The team created a bilingual video in which three Latinas shared their experiences with language barriers in healthcare in Kansas. The video was then shared with state legislators and healthcare administrators, prompting both groups to take initial steps toward improving policy (Showstack *et al.*, manuscript under review). A policy brief followed, which also included stakeholders' *testimonios*. The next step for *Alce su voz* is a series of workshops that will culminate in stakeholder creation of additional *testimonios*, short videos, and texts that will be disseminated electronically.

As applied linguists, we can study the impact and process of interprofessional communication with different modalities of interpreting, which can be best understood through applied linguistic theory and methods (Feuerherm *et al.* 2021). To achieve progress leading to greater health equity for speakers of minoritized languages, voices from a range of stakeholders can help determine the best way to proceed in multi-disciplinary and multi-stakeholder collaborations. Applied linguistics as a discipline, finally, offers tools to understand and advance health literacy by providing an explanatory analysis for how patient experiences inform their beliefs and outcomes (Rubin 2014). Linguists can provide 'epistemic brokering' (Raymond 2014) to work toward common ground, brokering knowledge to partner with health care personnel as they expand their own health literacy and communicate more meaningfully with Spanish-speaking patients.

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