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Forum: English Language Learners and Health Literacy

(Part 1 of 3)

Reflections on "Good" Language Learners, "Good" Patients, and Language

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If we ask adult English language learners what their goals are for learning English, they are not very likely to say, "I want to be a good English learner," but rather they will tell you what they want to *do* with English, such as to get a better job, to be able to speak for themselves at the doctor's office, to be able to take care of their family's health needs. Similarly, if we ask patients from linguistically minoritized backgrounds what their health goals are, they are not likely to say "I want to be a good patient who speaks good English" but rather they will focus on how they want to feel and what they'll be able to *do* as a patient.

With this Forum essay, I invite much needed dialogue - with adult English language educators, adult learners, and health practitioners – about the way we think about "good language learners," "good patients," and language. I highlight key points of overlap and divergence in debates about "good language learners" and "good patients." I also highlight some examples in health care where untested assumptions about the "good" linguistically minoritized patient can contribute to linguistic inequities and unjust health outcomes. The adult literacy classroom remains one of the most important platforms where we can deepen our understanding of the links between language, power, and health, and ultimately, can disrupt harmful representations of "good patients" in linguistically minoritized communities.

Revisiting the Concept of "Good Language Learner"

In language learning and teaching, we have a decades-long preoccupation with this question: what makes a good language learner (GLL)? Research on GLLs (Naiman et al., 1978; Oxford, 1990) emphasized that successful language learners exhibit key traits like high motivation, active engagement, and strategic use of learning habits and routines, including self-monitoring and problem-solving gambits, as typified in the list below.

Characteristics of the GLL:

1. they are good guessers
2. they pay analytical attention to form but also to meaning
3. they try out their new knowledge
4. they monitor their production and that of others
5. they constantly practice
6. they cope well with feelings of vulnerability for the sake of putting themselves in situations where they communicate and learn (Rubin, 1975, as cited in Ortega, 2009).

Critics argue that the GLL framework narrowly focuses on individual traits, often assuming that learners who struggle with English are not using the right strategies or not trying hard enough (e.g., Ricento, 2005; van Lier, 2010). More broadly, they contend that the framework ignores power imbalances between learners and speakers, often leaving learners to shoulder the bulk of the communicative labor (Briggs, 2017; Norton & Toohey, 2011). Traits #4 and #6 seem to even valorize the burden that language learners must accept to manage communication breakdowns and remain resilient in their interactions with target language speakers.

Identity theorists offer a compelling counterweight to the GLL framework, directing our focus to the social, cultural, and power dynamics that shape language

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learning outcomes (Duff, 2002; Motha & Lin, 2014; Norton, 2013). Norton's concept of "investment" provides an alternative to the prevailing focus on individual qualities in this way:

> The construct of investment…signals the socially and historically constructed relationship of learners to the target language and their often ambivalent desire to learn and practice it. If learners 'invest' in the target language, they do so with the understanding that they will acquire a wider range of symbolic and material resources, which will in turn increase the value of their cultural capital. Unlike notions of instrumental motivation, which often conceive of the language learner as having a unitary, fixed, and ahistorical 'personality,' the construct of investment conceives of the language learner as having a complex identity, changing across time and space, and reproduced in social interaction. (Norton, 2010, p. 353-354)

In other words, learners are not "good" or "bad" based on their skills, personality, motivation levels, or strategy use, but rather as a result of the social conditions that shape their agency, desires, and access to networks of other language users.

Exploring Perceptions of the "Good Patient"

Now let us turn to perceptions of "good patients" in health care. As an applied linguist, I am attuned to look for ways that language shapes the way we view 'good' patients in a myriad of ways: how patients express trust and engage with their health care providers, how they describe their health care concerns and medical history, how bilingual patients express pain or worry in specific languages, how they demonstrate respect and compliance to the practitioner's recommendations, and more. Just as language learners are often judged based on social expectations and power imbalances, patients also come to be categorized as "good" or "bad" based on their interactions with health care professionals. Kelly and May (1982) have argued that the good/bad labels do not describe patients but rather reflect providers' views about patients.

For example, Sointu (2017) carried out a 2-year interview study with U.S. medical students and grouped the doctor's descriptions of "good patients" under three major themes:

1. "Active participants in their healthcare", "trusts and respects the doctor"
2. "Compliant and knowledgeable" - "grateful of the care they're receiving"; "Knowing one's medical history"..."honest and upfront"
3. "Engenders positive feeling" - "you really feel like this is a team effort...The doctor and the patient are working together towards this goal." (pp. 68-69)

Fulfilling these expectations goes beyond just choosing the right words or sharing accurate information; rather it requires that patients use language to navigate social and power dynamics within the health care encounter.
As noted earlier, the "good language learner" framework includes the management of emotional labor as a valued trait. The linguistic demands of this emotional labor are evident in Khalil's (2009) survey of 270 nurses working in Cape Town, South Africa. Similar to Sointu (2017) in focus, Khalil (2009) identified five most frequent descriptors, which highlight efforts "good patients" must take to reduce the emotional charge of health care encounters:

1. "Friendly and calm most of the time"
2. "Accepts help without complaining"
3. "Very polite"
4. "Always does what he or she is told"
5. "Does not make too much fuss" (p. 438)

These descriptors reflect how patients are often expected to manage their behavior to align with health care norms. Similarly, Campbell (2015) found that, in community clinic settings where medical resources (staffing, medicine, medical supplies) may be limited, patients feel compelled to "'signal' their goodness and deservingness of treatment or their respect for the medical establishment" (p. 9) when talking to nursing staff. In other words, by getting on the nurses' "good side," the patients felt more assured of their chances of getting better care.

Socioeconomic inequities can shape whether a patient is viewed as "good" or "bad", which providers recognize as a problem but often don't know how to address. For example, in Sointu's (2017) study, a provider commented, "If you can't get yourself the care that the doctor wants you to do, if you don't have money to do that, that unintentionally puts you in the bad patient category" (p. 70). Sointu (2017) also observed that medical students' training often perpetuated harmful stereotypes of "good" and "bad" patients, with few to no opportunities to talk

about moral dilemmas and conflicted emotions (e.g., seeing their attending physician roll their eyes upon hearing a "difficult" patient's name).

Studies on "good language learners" and "good patient persona" both tend to focus on perceptions of learners/patients during spoken interactions, but we have much to learn about how patients navigate social dynamics across modalities, spoken and written, and increasingly, in digital environments via patient portals and telehealth appointments. Martinez (2008) offers a compelling example of Spanish-English bilingual patients who recounted experiences where medical providers offered oral Spanish translations of written English medical directives when no printed materials in Spanish were available. The patients felt that the brief oral translations were merely a "surrogate" for the more detailed written information in English. Martinez argues that the treatment of Spanish as the "non-literate language," i.e., the "deliteracization of Spanish", has both ideological and practical consequences that reflect the "ubiquitous privileging of English literacy" (p. 356) and contribute to "fractured and non-reinforced transmission of health information" (p. 357). What is particularly concerning here is the potential for bilingual individuals to view their 'good patient persona' through the "dominant gaze" (p. 87) of English-based health literacy. What might seem like an effort to provide linguistic access actually reinforces English as the preferred language for health care communication - and thus the only language to enact one's "good patient persona."

To close this exploration of the 'good patient' literature, I'll point out that my efforts to find studies on "good *bilingual* patients" often led to dead ends. The lack of literature in this regard suggests a lack of appreciation for the communicative and emotional labor of bilingual patients (see Briggs, 2017). We need a deeper interrogation of any existing literature and replication studies about the representation of "good" or "difficult" bilingual patients.

What Do Adult English Learners Say About the "Good" Patient?

Thus far, we have looked at how scholars have studied "good" learners and "good" patients from the practitioner perspective. In fact, my personal take-away from two decades of health literacy work in classrooms is that we need to center the voices of learners themselves, as they have much to teach us about the social conditions, specifically the power dynamics in their everyday health care encounters. I'll share an example from a beginning-level ESL class when our learners read and discussed one of Kate Singleton's (n.d.) ESL Picture Story entitled "A Doctor's Appointment": a man goes to the doctor about stomach pain. After an examination, the doctor offers an explanation with a lot of jargon, and then asks if the man has any questions. The man does not understand but back-channels to the doctor "ok" and "yes". The man does not ask any questions about the diagnosis or the prescriptions he is given. The man goes home, and when his partner asks him, "What did the doctor say?", the man replies, looking exasperated, "I don't know!"

We asked our learners, "why does the man say 'yes' and 'ok' to the doctor?," and their answers reveal an understanding of 'ambivalent desires' to use English (see Norton, 2013) in health care settings. Here's a sampler of what learners shared:

- The man says 'yes' because he respects the doctor.
- The man says 'ok' because he's embarrassed. He doesn't take care of his health.
- If you ask a question then they give you more information in English that you don't understand, so it's better to say ok.
- He's embarrassed to use English to ask more questions.
- He doesn't have time to think about his questions.
- He has a lot of pain so it's hard to think in English. He needs medicine.
- He's worried about the cause for his pain.

Our learners did not characterize the man as unmotivated to speak English. Instead, their answers reveal a discerning view of the man's "ambivalent desires" to speak up (e.g., needing medical care but afraid of being judged). The learners also sympathized with the man's preference for silence over embarrassment. In the learners' answers we also see symbolic resources the man draws upon (e.g., cultural norms about respect before medical authorities) to better position himself to get good care. The learners considered the possibility that the man was so worried

about a bad diagnosis that he could not focus on the doctor's explanation, and the doctor's voice just faded to *blah blah blah*. It is easy to understand why the man would *not* be invested in meaning negotiation given that the doctor's jargon-filled lecture makes the information materially useless.

The "Doctor's Appointment" Picture Story invites learners to name unrealistic expectations of "good" patients and interrogate the stigma associated with linguistic minoritization in health care. As evident in the ESL Picture Story example, classrooms are places where learners can practice enacting their linguistic rights as patients and affirm their desire to speak up. In short, our mandate in health literacy pedagogy is not only about closing a gap in English proficiency but also to strengthen their capacity to be heard in health care contexts (Auerbach, 1992; Handley et al., 2022; Santos et al., 2011).

...But, Wait, How Do You Enact Your Linguistic Rights in 18 Minutes or Less?

I would like to briefly address the time constraints that limit effective communication for both patients and providers. When discussing the ESL Picture Story in our classrooms, we did not hear our learners disparaging the doctor; learners recognized that doctors are often stressed and under pressure to see many patients. Indeed, the average length of a doctor's visit is only about 18 minutes (Nephrash, etal., 2023). Visits with an interpreter can last 40-90 minutes (Torresday et al., 2024), although the provision of such linguistic support is not a given.

A physician feeling pressured by time to "get by" without an interpreter using just a few words in the patient's language is less likely to be invested in negotiating meaning, which diminishes the efficacy of the learner's efforts to negotiate as well (see Diamond et al., 2008). On the other hand, if patients feel included in the negotiation of meaning, their sense of legitimacy as a patient is strengthened. We must better understand our learners' efforts to use their English language and health literacy skills within the context of the social conditions (the time pressures, the norms, policies, the relationships) that enable or constrain those efforts.

Through interdisciplinary dialogue, adult educators, applied linguists, and heatlh practitioners should critically examine the term "poor historian," a label commonly used in medical charts to describe patients who struggle to provide clear and accurate health information—often due to limited language proficiency or low health literacy (Green & Nze, 2017). The perspectives of adult learners and educators are crucial for challenging this stigmatizing language and confronting the social and structural barriers that prevent patients from being heard and understood in clinical settings (see Goddu et al., 2019; Healy et al., 2022).

Pushing Past Labels and Perceptions

An equity-driven response to harmful representations of "good" patients requires a serious respect for language, as explained by my colleague Glenn Martinez: "There is also a need to feel accepted, welcomed, and justly heard in the healthcare encounter. Lack of acceptance leads to mistrust between patients and providers and has the potential to override any gains realized through access.... Perhaps a patient's lack of compliance....is nothing more than a symptom of a lack of trust" (Santos et al., 2023, p. 4).

Access to information and care is a necessary material resource, but language acceptance holds symbolic power, bringing legitimacy to a patient's ability to be heard. Indeed, we have a moral imperative to interrogate our assumptions about "good" language learners and "good" linguistically minoritized patients; that critical inquiry will reveal our commitment to language access and language acceptance. We have yet to fully examine what "good" or even "good enough" communication practices support meaningful access and language acceptance (see Ortega & Prada, 2020). Nor have we sufficiently tapped into the expertise that adult educators and learners can bring to critical reflection on access versus acceptance (Harsch & Santos, 2024).

If we take the constructs of *investment*, *language acceptance*, and *symbolic power* as essential starting points and outcomes in health literacy pedagogy, we are better poised to understand learners' real-world desires and ambivalences. Norton's call for new lines of inquiry suggest we should be pursuing answers to critical questions about learners' investment in English learning and gaining new

health literacy practices: To what extent are health care needs shaping our learners' investment in learning English? How invested is a learner in learning and practicing English in their everyday health care decision-making, and what opportunities do they have to act on this desire? In their health care interactions, when do learners experience an "ambivalent desire" to use English, and what does this look and feel like? What symbolic resources (e.g., increased agency as a patient) and material resources (e.g., a job that comes with health benefits) do our learners value? What kinds of ESL classroom practices do learners invest in because they see the value of these practices to their ability to live well and stay well? We need a coordinated research agenda – which includes sustained investment of time and resources into adult education partnerships – that addresses these questions if we are to better understand the relationship between language learning, health literacy, and patient agency.

Conclusion

In this essay, I have explored perspectives on "good language learners" and "good patients" to draw attention to the ways our expectations of "good" are shaped by social conditions as well as assumptions about language and language users. Left unchecked, these biases about 'goodness' can contribute to linguistic inequities and unfair health outcomes. Like many *ALE* readers, I still believe the classroom offers a place for us to act on our commitment to learner empowerment as a meaningful learning outcome. The voices and stories of linguistically minority learners/patients can educate us about the material access to resources and symbolic recognition our learners value. Indeed, we have a moral imperative to interrogate our assumptions about "good" language learners and "good" linguistically minoritized patients; that critical inquiry will reveal our commitment to language access and language acceptance.

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