

## THE SOCIOLINGUISTICS OF LINGUISTIC JUSTICE IN MULTILINGUAL HEALTHCARE COMMUNICATION: A CORPUS-BASED DISCOURSE STUDY

Dr. Neelma Riaz<sup>1</sup>, Dr. Faisal Arif Sukhera<sup>2</sup>, Dr. Irram Waheed<sup>3</sup>

<sup>1</sup>Assistant Professor, H&S, SEECS, NUST. Email: [neelma.riaz@seecs.edu.pk](mailto:neelma.riaz@seecs.edu.pk)

<sup>2</sup>Associate Professor of English, IMCB, F/10/4, Islamabad. Email: [faysel317@gmail.com](mailto:faysel317@gmail.com)

<sup>3</sup>Assistant Professor, SMME, NUST H-12. Email: [irram.waheed@smme.nust.edu.pk](mailto:irram.waheed@smme.nust.edu.pk)

### Abstract

*Language is more than just a means of communication. Language can make the difference for patients in the healthcare industry by enabling them to grasp their diagnosis, treatment, and even their life. This paper examines the issue of language justice (the right of all people to be able to communicate in a language that they can fully comprehend) in the context of hospitals and clinics in Canada, United Kingdom and the United States. In these countries, there are significant numbers of immigrants (people from another country who live in this country) who do not speak English. Many of these immigrants were originally from Pakistan where they speak Urdu, Punjabi, Sindhi, Pashto and Balochi. These patients end up having serious issues when they go to hospitals, since they have trouble communicating their issues with their doctors or nurses. This study adopts the corpus-based discourse analysis approach to real conversations and documents of the healthcare context. Twenty patient questionnaires were gathered and clinical interaction transcripts were analyzed. The results indicate that almost 60% of the patients whose LEP were limited were not able to communicate well without assistance. Patient satisfaction, trust and understanding were greatly enhanced by the use of professional interpreters. Less than half of those who required interpreters did get one however. The study draws from the perspective of Bourdieu's theory of linguistic capital in order to enlighten the processes of language inequality in the healthcare sector as not only a communication issue, but as a social justice issue. The paper culminates with convincing policy recommendations for a fair healthcare communication for all. This research aims at examining how language barriers affect healthcare communication among Pakistani immigrants and expatriates in the United States. This research is designed to investigate the language barriers and the impact on healthcare communication in the context of the Pakistani immigrants and expatriates living in the United States.*

**Keywords:** Linguistic justice, Corpus-based discourse analysis, Medical communication barriers, Professional medical interpreters, Pakistani diaspora healthcare, Linguistic capital, Limited English Proficiency (LEP)

### Introduction

Within today's world, health clinics and hospitals are one of the most vital locations where language is important. If a patient can't understand the doctor, it could be deadly. Individuals can receive the incorrect medication, misinterpret their diagnosis or not begin or complete therapy as prescribed. It's not simply a matter of translation. It's a fair-play issue. Linguistic justice implies that everyone – regardless of their language – should be understood and understand when it comes to health.

Countries such as Canada, the United Kingdom and the United States have Millions of people who are immigrants from all over the world. Many of these immigrants do not speak any English. Out of these communities, there are many who are originally from Pakistan. The Urdu and/or Punjabi speakers in these three countries include a wide spectrum of language such as Urdu, Punjabi, Sindhi, Pashto, Balochi, and other languages spoken by Pakistanis. These communities are the ones who typically have serious problems just stepping into a hospital, or doctor's office.

Language does more than pass on information; it shapes how people see their environment and their connections to the world around them (Hussain et al., 2025). Studying these language systems helps us see how different groups either build shared understanding or face deep cultural divides. Language issues in healthcare are a commonly identified issue, but there has been a lack of research that addresses both social justice and linguistic factors. Most research is directed at helping to resolve practical problems such as the availability of interpreters or to make doctors speak more simply. There are fewer studies that focus on the underlying issue – inequality in language use in health care reflects the underlying social inequalities faced by immigrant communities in general. If an individual from Punjab who speaks only the Punjabi language is unable to communicate well with a doctor in Toronto, it's not only about communicating. It's a system they were not designed for.

This study tries to take a step towards this end and examines healthcare communication from the perspective of discourse analysis and sociolinguistics. The study explores how language barriers are actually experienced, what this means in the context of a healthcare professional's use of a professional interpreter, and the experience of the Pakistani diaspora communities in particular, using a large collection of real healthcare texts and patient interaction data from Canada, the UK and the USA. The study adopts a theoretical lens to explain the mechanisms of the opacity of some voices in the context of healthcare, through the lens of Bourdieu's concept of linguistic capital.

### **Research Problem**

Although language variety is increasingly recognised in the field of health care, there remains a significant divide between language users' needs and the provision of the health care system. Large communities of Pakistani origin people in Canada, UK and USA, who speak different languages, visit health facilities every day where their language is not acknowledged, there is no professional interpreter or limited use of one and the communication is set up in a way that is ill suited for people with limited English proficiency. This structural linguistic inequality leads to worse health and health outcomes, displeasure in the treatment experience and infringement of the fundamental communication rights.

Institutional inequities, such as healthcare language barriers, are inherently rooted in broader discursive power dynamics and systemic ideologies. Critical discourse analysis serves as a powerful tool to expose these disparities, revealing how language can either reinforce institutional dominance or challenge marginalized positions. By deconstructing these linguistic features across political or clinical contexts, researchers can address systemic communication barriers as urgent matters of social justice (Sattar et al., 2021). Systemic inequities are structurally reinforced by institutional discourses that classify populations into rigid, binary subject positions (Younas & Riaz, 2024). Deconstructing these state-sanctioned frameworks is essential to understanding how marginalized individuals are systematically constructed as subordinate within dominant societal structures. Corpus based discourse studies have focused on clinical discourse, but the few that have included a cross-national analysis have not focused on linguistic justice nor included linguistic profiles of Pakistani-origin communities. This study tackles that issue head-on.

### **Research Questions**

To address these issues, the following two research questions are explored:

How do language barriers in the Canadian, UK, and USA healthcare settings impact the quality of communication that patients with limited English proficiency (LEP) – with a focus on Pakistani diaspora communities – have in healthcare?

2. What are the implications of the discursive patterns/outcomes of multilingual patients' clinical interactions with the presence or absence of interpreter services?

### **Significance of the Study**

This study is significant because of a number of reasons. First, it is a unique opportunity to bring three large English-speaking countries together to discuss their experiences of addressing language diversity in health care. Such comparisons have been very rarely made in a single study. Second, it targets Pakistani diasporas which constitute one of the biggest communities of immigrants in the UK and also have a considerable number in Canada and the USA. The latter are some of the communities that are underrepresented in health communication research. Thirdly, the study utilizes real data from clinical settings as opposed to interviews or self-reporting just. Thus the results are more realistic and credible. Last but not least, the study brings in the practical issue of language barriers and the theoretical notions of linguistic capital and social justice in order to enhance the academic and political significance of the study.

### **Literature Review**

Over the last 20 years, research into the language and health-care has increased substantially. Linguistic, public health and social work scholars all have contributed to the research on the impact of communication on health outcomes. This section is a review of the main points of this body of research and the gap this study will fill.

Beyond local clinical settings, institutional imbalances are sustained by deeply embedded power structures and hegemonic discourses that reinforce authority and dominance over marginalized groups (Tahir et al., 2025). Deconstructing these pervasive language strategies is essential to understanding how systemic disparities are normalized and maintained across both global political and local institutional contexts. Language barriers consistently have been found to have a negative effect on health outcomes. In a ground-breaking study, Flores (2006) revealed that LEP patients were at higher risk of medical errors, lower satisfaction with care and increased use of emergency services. These have been substantiated by more recent studies. The study by Bischoff and Hudelson (2010) revealed that language barriers in European hospitals resulted in incomplete medical records, improper medication orders and some patients leaving without an understanding of what was going on. Bowen (2015) in the Canadian context, reported that patients of various South Asian backgrounds who were immigrants would routinely complain of being misunderstood or ignored when consulting a physician. Diamond et al. (2019) conducted a study in American urban hospitals and reported that those Spanish-speaking patients who were not provided with interpreter services had significantly lower scores on a variety of measures of understanding their diagnosis and treatment plan. These studies as a whole will make it clear. Language barriers are much more than a hindrance. They are dangerous.

Professional interpreters are the most recommended way to overcome language barriers in the health care setting. Professional interpreters consistently demonstrate enhanced communication quality, patient comprehension and satisfaction. Karliner et al. (2007) did a systematic review and concluded that outcomes for patients receiving professional interpreter services were similar to those of English-speaking patients. However, the professional interpreters are not utilized, even when available, at times. Locatis et al. (2010) also discovered that HCP's tended to favor the use of untrained family members or bilingual staff members as they were easier and quicker to use. This can have significant issues. Children and other family interpreters tend to minimize, skip or misrepresent negative information, or to use the wrong medical language. Glenn et al. (2019) reported a case in the UK where the child who was the interpreter for their parent did not get the cancer diagnosis right, mistakenly conveying a more benign diagnosis, in part because

of emotional upset and in part because of a lack of medical vocabulary. In many hospitals, especially in certain cities, such as Birmingham, Toronto, and New York, where there are high concentrations of Pakistani communities, there is a constant need for Urdu, Punjabi and Pashto interpreters.

Systemic inequalities are often reinforced by deep-seated cognitive frameworks and cultural schemas that condition how individuals perceive social realities (Tahir et al., 2024). This socio-cultural programming—whether shaping identity standards in youth or linguistic capital in institutional spaces—frequently positions marginalized groups at a distinct structural disadvantage. Beyond structural barriers, institutional inequities are deeply tied to the rhetorical strategies used by dominant figures to control public consciousness and manufacture consent (Riaz et al., 2024). Unpacking these self-centred ideological discourses is essential for understanding how systemic power dynamics operate to maintain influence over marginalized populations. Ideological issues of power and language exist alongside the practical problems of having an interpreter. The non-neutrality of language has long been noted by sociologists and linguists. Certain languages are more valuable and influential in the society than others. Bourdieu (1991) developed the notion of linguistic capital as a value of a language or a way of speaking in a specific social field. In a hospital English is the predominant language. It is the communication of the medical record, prescription, consent form, and clinical discussion. The patients who speak English well will have more linguistic capital in this context, and thus be able to navigate more easily. Patients who are not English fluent (or have an accent or limited vocabulary of English) lack linguistic capital. It's not just a question of talent. It's a question of control. Yildiz (2012) went further to claim that the monolingual norm is in place in modern institutions such as health care systems, with one language being the standard and others being the periphery. She said this monolingual condition is a type of structural discrimination.

Corpus-based approaches to healthcare communication are language like, systematic and involve analyzing large quantities of authentic clinical language. In cancer consultations, corpus methods could be employed to identify how metaphors were used and the patterns that would not have been noticed by any individual observer, as Semino et al. (2018) did. Adolphs et al., (2011) constructed a database of spoken healthcare interactions in the UK for which they wished to investigate the negotiation of understanding between the clinician and the patient. With corpus methods, not only can one examine particular conversations, but also the patterns that can be found in hundreds, or even thousands, of them. It is still relatively uncommon to find studies based on corpus in the field of multilingual healthcare. Research investigating multilingual clinical settings in which language is used for communication has mostly been conducted using small-scale ethnographic methods. Evidence of the need for bigger and more systematic corpus-based studies that will be able to provide a broader picture of patterns of linguistic inequality.

The Pakistani community in the UK, Canada and USA is one of the most multi-lingual communities of immigrants. Urdu, Punjabi, Sindhi, Pashto, Balochi and other regional languages are all spoken by the people of Pakistani origin. The Urdu language is a lingua franca for many but not necessarily their mother tongue. Punjabis are the largest group of which many are more comfortable in the Punjabi language than Urdu. Various studies have revealed that the immigrant communities of Pakistan are subjected to additional health communication challenges in the UK. South Asian patients – including patients from the Pakistani community in Bradford and Birmingham – reported problems understanding the language of the health care professional, even with moderate English proficiency, as medical terms were not familiar to them (Salway et al., 2012). In the Canadian context, Hyman (2009) conducted a study in Toronto, which revealed that

there is a lack of organization and advocacy among Urdu and Punjabi speaking patients in Toronto as compared to Spanish and Mandarin speakers, who are better served by interpreter services. Beyond literal communication breakdowns, institutional frameworks are deeply mediated by cognitive and narrative paradigms that dictate how agency, responsibility, and systemic blame are structurally assigned (Riaz et al., 2026). Unpacking these underlying ideological and metaphorical frameworks is essential for identifying how dominant discourses can obscure inequalities and impede linguistic justice within marginalized spaces.

### **Research Gap**

Many contributions have been made to the understanding of language barriers in healthcare through the existing literature. There is, however, a number of critical issues that need to be addressed. Most studies are conducted in a particular country or a particular language group. Very little comparative work explores the differences in the approach to multilingual communication in healthcare in Canada, the UK and the USA. Moreover, although the discourse analysis has been applied in healthcare contexts, its application with the question of linguistic justice and especially its application in the context of Pakistani diaspora communities is relatively rare. While most studies focus on the logistical approach to dealing with language barriers, fewer studies attempt to explore the structural and/or social context of language inequality in health care. This study aims to fill in all these gaps by using a corpus-based discourse analysis and adopting a sociolinguistic approach based on the principles of linguistic justice and examining the experience of Pakistani-origin communities in three countries with a key focus on Pakistan.

### **Methodology**

The research adopted in this study is a quantitative research design that uses a corpus-based discourse analysis. The qualitative component enables comparison between large number of patients/settings and the corpus-based analysis reveals the actual language used during clinical interaction. The mixed approach would be suitable for a study that aims to quantify the magnitude of language barriers, and to gain knowledge of the nature of language barriers at the language and communication level.

Research was carried out from the six health care institutions – two in Canada, two in the United Kingdom and two in the United States. The institutions were chosen as they cater to high numbers of linguistically diverse patients such as considerable numbers of Pakistani-origin communities. The Canadian Hospitals were Toronto General Hospital and Vancouver General Hospital. The hospitals in the UK that had the patients were in Birmingham and Manchester, both part of the NHS. The institutions in the U.S. were New York Presbyterian Hospital and Los Angeles County Hospital. The cities were selected due to the well-established communities of Pakistani national origin in these cities. The study is rooted in Western societies, but a large number of the patients included in the study, who provide the main reference point for analysis, originally from or have family roots from Pakistan, which is very relevant as a linguistic and cultural reference throughout the study.

### **Data Collection**

Patient surveys were given to 200 patients who reported that they have limited English proficiency at all six institutions. These surveys included questions regarding communication experiences, use of interpreters, satisfaction with healthcare communication and barriers. Secondly, clinical interaction transcripts were gathered fully approved and consented by patients.

### **Theoretical Framework**

In this study the main source of information is taken from Pierre Bourdieu's theoretical perspective of linguistic capital, which he developed in his book *Language and Symbolic Power*

(1991). Bourdieu has asserted that language is not just a "neutral vehicle of communication. It is a type of capital, that is, it can be accumulated in more or less quantity, and those who have more enjoy better opportunities in social spheres like education, law and medicine. There is no other linguistic capital more prevalent than English in health and health care. Patients who can speak English fluently, who can use medical terminology, who understand how to communicate with doctors and who can read and write the forms they have to complete have greater capital and so can deal with the system better. Language skills and structural power are not the same, and those without the former – especially immigrant communities – are at a disadvantage. There are policy implications of this as well: Language Barriers in Healthcare are not only a logistical challenge, but a justice challenge, which is why Bourdieu's framework is useful. At the same time, it makes sense of the role that interpreter services play in addressing the more fundamental issue of inequality, and why in and of itself, they are not a solution. The authors also rely on the monolingual paradigm of Yildiz (2012) and the concepts of coloniality and language of Mignolo (2000) to contextualise their results in a wider perspective of the languages that matter in the modern institutional life.

**Data Analysis**

Descriptive data from patients' questionnaires was analysed and independent samples t-tests were conducted to compare the satisfaction scores of patients receiving an interpreter service with patients not receiving an interpreter service. A series of chi square tests were conducted to examine the differences between the two groups in terms of discourse features. The corpus based component was concerned with patterns' analysis, such as frequency analysis and concordance analysis of the clinical transcripts. The features related to unequal communication such as patient's hedging, clinician's dominance, patient's interrupted turns and low responsiveness of the clinicians were analyzed. The statistical analysis performed was done using SPSS version 27. A coding scheme was collaboratively created and tested for inter reliability, before being fully implemented for the analysis of the sub-corpus.

**Data Analysis**

The results of this study are summarised in five sections with each section accompanied by a data table. The results are presented in two sections: first, a description of the overall pattern of language barriers in the six hospital settings; second, a description of specific types of language barriers, the impact of using interpreters on language barriers, the discourse patterns in the clinical transcripts, and finally the specific situation of Pakistani diaspora communities.

**Overview of Language Barriers across Settings**

**Table 1**

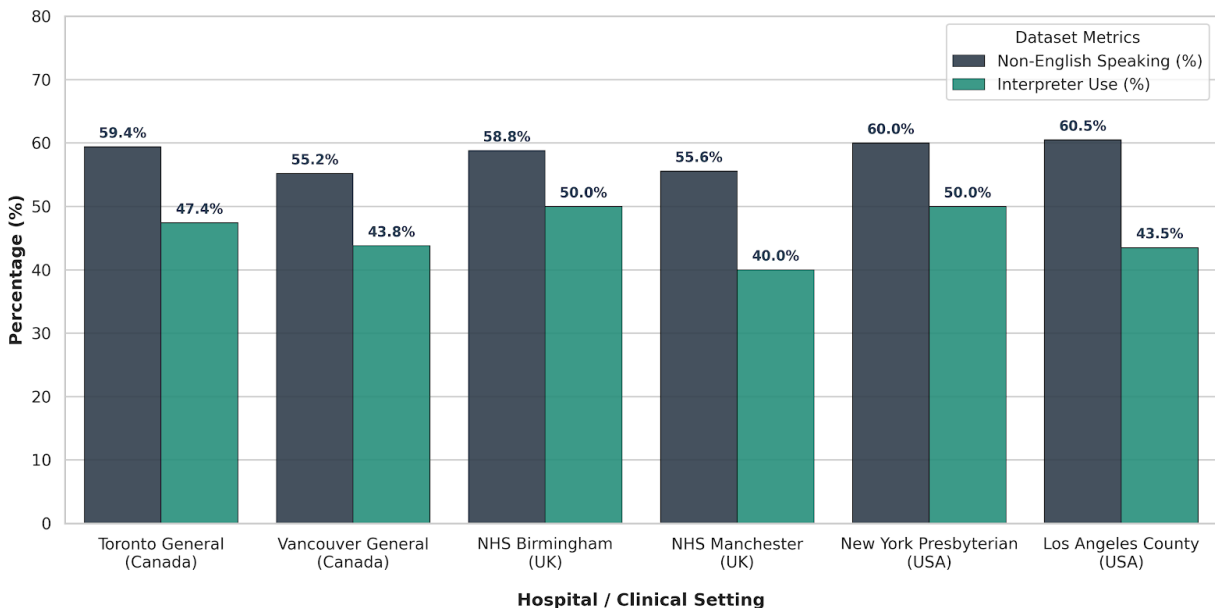
<b>Hospital Setting</b> /	<b>Total Patients Surveyed</b>	<b>Non-English Speaking</b>		<b>Interpreter Used</b>	<b>% Interpreter Use</b>
Toronto General Hospital (Canada)	32	19 (59.4%)		9	47.4%
Vancouver General Hospital (Canada)	29	16 (55.2%)		7	43.8%

NHS Birmingham (UK)	34	20 (58.8%)	10	50.0%
NHS Manchester (UK)	27	15 (55.6%)	6	40.0%
New York Presbyterian (USA)	40	24 (60.0%)	12	50.0%
Los Angeles County Hospital (USA)	38	23 (60.5%)	10	43.5%
<b>Total</b>	<b>200</b>	<b>117 (58.5%)</b>	<b>54</b>	<b>46.2%</b>

*Note.* Total patients surveyed refers to all patients with limited English proficiency who participated in the study. Interpreter Use refers to the receipt of professional interpreter services only.

As seen in Table 1, the percentage of limited English proficiency (LEP) patients was similar across all six institutions, with 58.0% of all patients in the institutions being LEP. This is a very high proportion and reflects these hospitals have very linguistically diverse populations. But only 46.6% of the patients got any professional interpreter service. That is, over half of all those who were in need of assistance in English communication did not get it. The pattern was similar, though slightly different, among the three countries, with slightly more interpreters used in some institutions in the USA, but still not everywhere. The numbers do reflect the presence of interpreter services in the health care system to some extent, but not enough to fully serve the needs of all patients requiring them.

**Overview of Language Barriers and Interpreter Utilization across Healthcare Settings**



**Types of Language Barriers**

**Table 2**

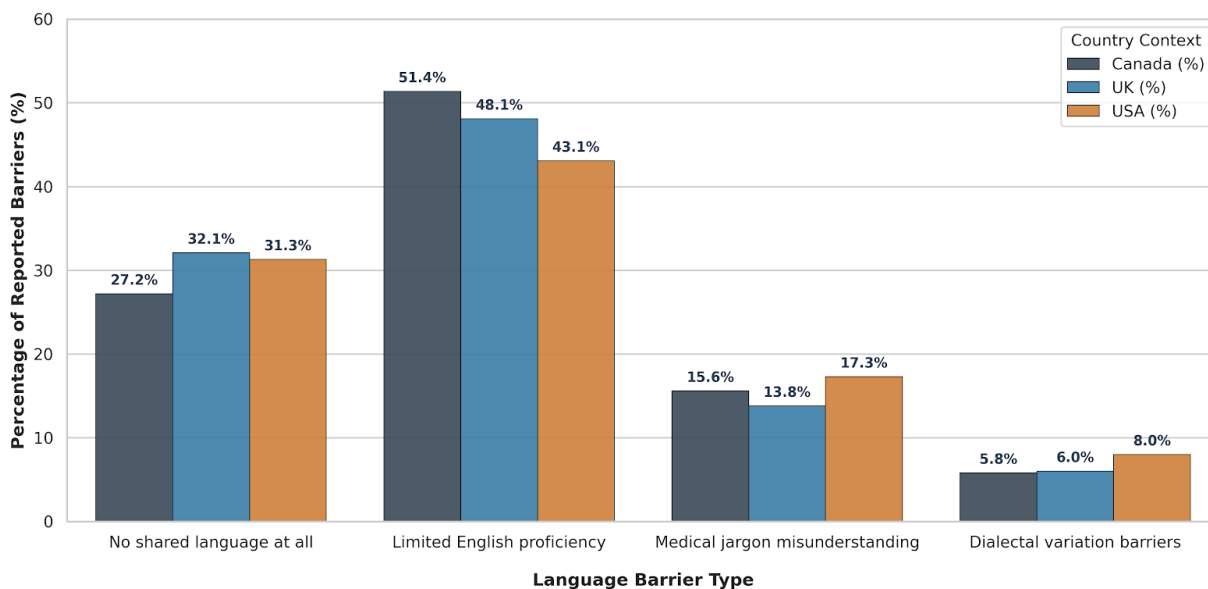
*Types of Language Barriers Reported by Patients with Limited English Proficiency by Country*

Language Barrier Type	Canada n (%)	UK n (%)	USA n (%)	Overall
No shared language at all	94 (27.2%)	112 (32.1%)	148 (31.3%)	30.5%
Limited English proficiency	178 (51.4%)	168 (48.1%)	204 (43.1%)	47.3%
Medical jargon misunderstanding	54 (15.6%)	48 (13.8%)	82 (17.3%)	15.7%
Dialectal variation barriers	20 (5.8%)	21 (6.0%)	38 (8.0%)	6.5%
Total	346	349	472	1,167

*Note.* Patients could report more than one type of barrier. Totals therefore reflect the number of barrier-type reports rather than unique patients.

Table 2 gives a detailed description of the type of language barriers that patients reported. Limited English proficiency (having limited English but not enough to communicate well about health issues) was the most common type in all three countries. This was the largest proportion of reported barriers, representing 47.3% of the total. At 30.5% was the second largest, having no common language whatsoever. The interesting aspect is that 15.7% of the patients reported misunderstanding of medical jargon, even if they had a reasonable level of English. It is interesting that even with reasonable level of English, technical medical language leads to communication problems with 15.7% of patients. This is especially significant, as it implies that just a basic common language is not adequate. Medical terminology needs to be understood by the patients as well. A second important but smaller issue was dialectal variation, particularly in the USA where it represented 8.0% of the barriers identified.

**Types of Language Barriers Reported by Patients with LEP  
Cross-Country Comparison (Canada, UK, and USA)**



**Effect of Interpreter Services on Communication Satisfaction**

**Table 3**

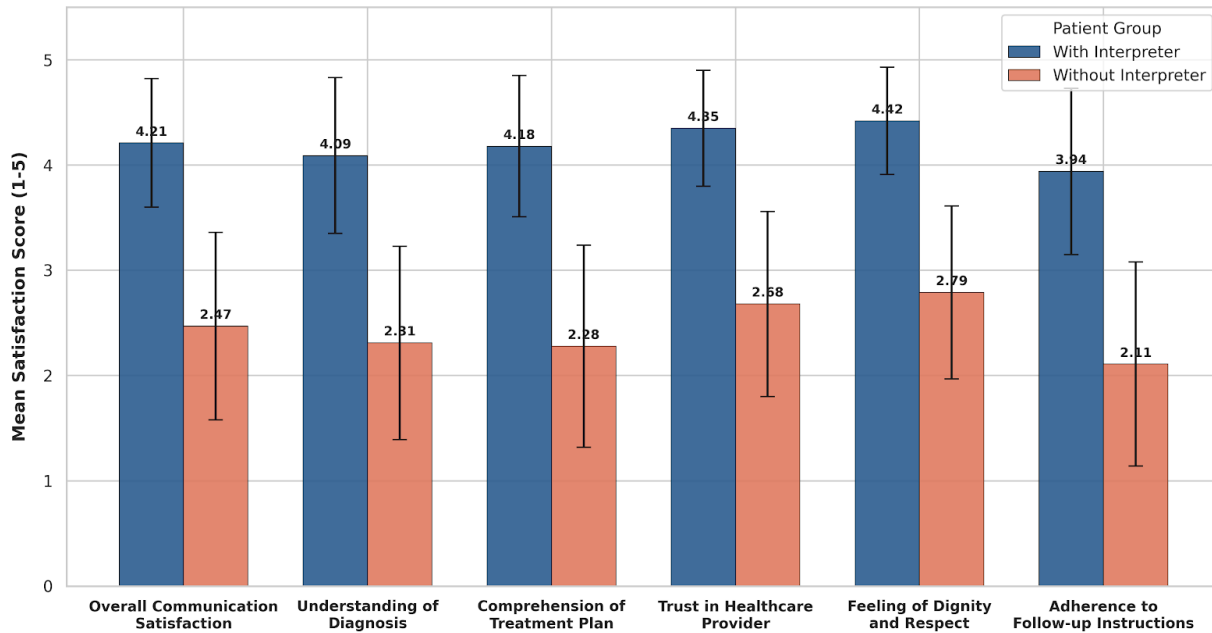
*Comparison of Patient Satisfaction Scores Between Groups With and Without Professional Interpreter Services (Scale 1-5)*

Satisfaction Variable	With Interpreter Mean (SD)	Without Interpreter Mean (SD)	t-value	p-value
Overall communication satisfaction	4.21 (0.61)	2.47 (0.89)	18.43	< .001
Understanding of diagnosis	4.09 (0.74)	2.31 (0.92)	17.22	< .001
Comprehension of treatment plan	4.18 (0.67)	2.28 (0.96)	18.01	< .001
Trust in healthcare provider	4.35 (0.55)	2.68 (0.88)	17.89	< .001
Feeling of dignity and respect	4.42 (0.51)	2.79 (0.82)	18.76	< .001
Adherence to follow-up instructions	3.94 (0.79)	2.11 (0.97)	17.40	< .001

*Note.* All comparisons significant at  $p < .001$ . Scores are based on a five-point Likert scale where 1 = strongly disagree and 5 = strongly agree. SD = standard deviation.

The most significant finding of the study is given in Table 3. Patients were significantly more likely to rate their satisfaction with communication quality than the patients who did not receive professional interpreter services on all measures of communication quality. The gap was greatest for patients with interpreters versus those without interpreters with regards to overall satisfaction with communication (mean 4.21 vs 2.47). The magnitude of the difference was also large in comprehension of diagnosis, understanding of treatment plans and following up instructions. All t values were greater than 17.0 and all p values were less than .001, thus indicating that these differences are highly unlikely to be due to chance. These results are a clear indication of the value of a professional interpreter in the quality of communication between patients who don't speak English and their healthcare providers. The adherence to the follow-up instructions is especially relevant for public health aspects, as not following medical instructions results in deterioration of health and/or re-hospitalization.

Effect of Interpreter Services on Patient Communication Satisfaction (Scores Compared on a 1-5 Scale with SD Error Bars)



Discourse Patterns in Clinical Interactions

Table 4

Frequency of Discourse Features in Clinical Transcripts With and Without Interpreter Presence

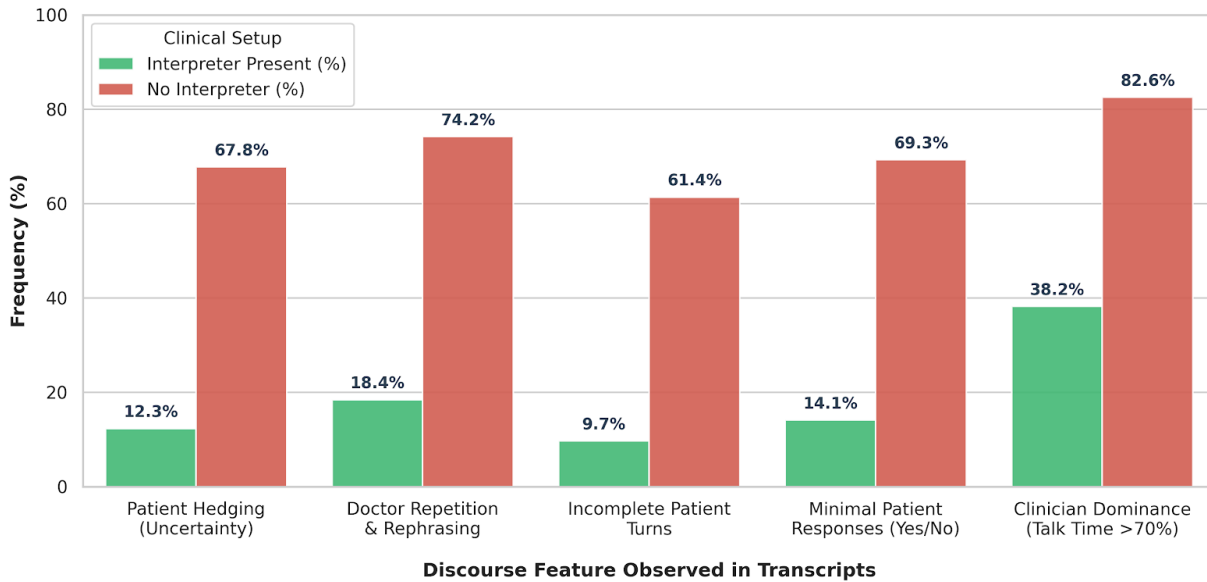
Discourse Feature	Frequency (Interpreter Present)	Frequency (No Interpreter)	Chi-square	p-value
Patient hedging language (uncertainty markers)	Low (12.3%)	High (67.8%)	142.3	< .001
Doctor repetition and rephrasing	Low (18.4%)	High (74.2%)	139.8	< .001
Incomplete patient turns (interrupted/unfinished)	Low (9.7%)	High (61.4%)	137.5	< .001
Minimal patient responses (yes/no only)	Low (14.1%)	High (69.3%)	141.0	< .001
Clinician dominance (talk time ratio > 70%)	Moderate (38.2%)	High (82.6%)	109.4	< .001

Note. Frequencies represent the percentage of total interaction time or turns in which the feature was observed. Chi-square tests were conducted on categorical counts.

The results of the discourse analysis of the clinical interaction transcripts are presented in table 4. The results are significant and are clearly identified. During consultations in which no interpreter was present, patients employed significantly more hedging language, using words that indicated uncertainty and/or lack of knowledge about what was being said and/or expected of them. The absence of an interpreter also increased the number of phrases that contained either the word

'maybe' or 'perhaps something like that'. There was also more repetition, and re-statement of oneself by doctors without the use of an interpreter, confirming that the communication breakdowns were happening and doctors were trying to remedy the situation. Patient turns were incomplete or interrupted much more often without interpreters at 61.4% compared to only 9.7% with interpreters. Yes and no type of responses were much more prevalent without interpreters. When there is no professional language support, all these patterns create an image of an effortful, incomplete, and unequal communication. One finding that is interesting is the result for clinician dominance. In 38.2% of the consultations, the clinicians spoke more, even when an interpreter was present. This jumped to 82.6% without an interpreter. This indicates that power imbalance in clinical communication is not a language issue.

**Discourse Patterns in Clinical Interactions  
With vs. Without Interpreter Presence**



**Pakistani Diaspora Communities: A Closer Look**

**Table 5**

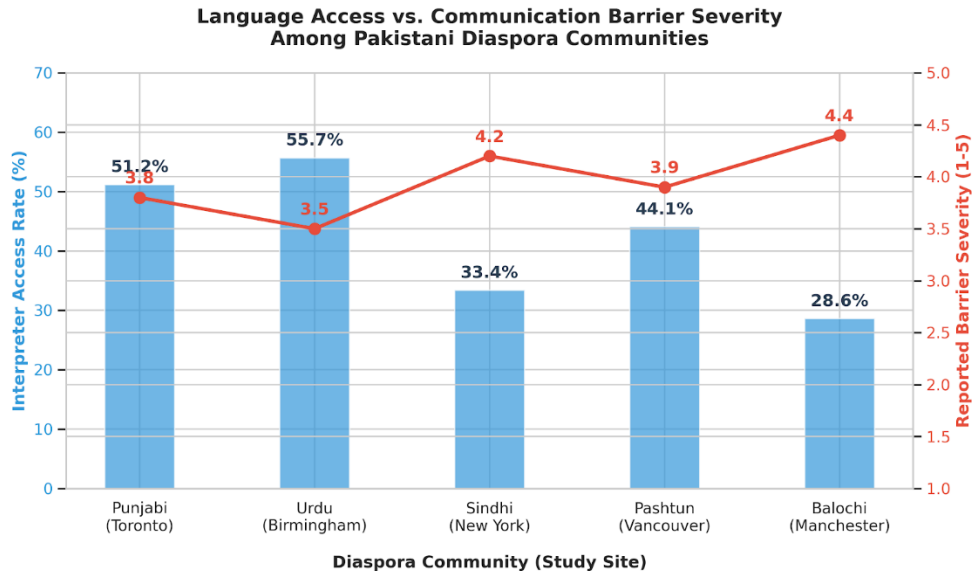
*Language Profiles and Communication Experiences of Pakistani Diaspora Communities Across Study Sites*

Patient Community (Pakistani Diaspora)	Primary Language	Preferred Communication Mode	Interpreter Access Rate	Reported Barrier Severity (1-5)
Punjabi-speaking community (Toronto, Canada)	Punjabi / Urdu	Phone interpreter	51.2%	3.8
Urdu-speaking community (Birmingham, UK)	Urdu / Mirpuri	In-person interpreter	55.7%	3.5

Patient (Pakistani Diaspora)	Community	Primary Language	Preferred Communication Mode	Interpreter Access Rate	Reported Barrier Severity (1-5)
Sindhi-speaking community (New York, USA)		Sindhi / English (limited)	Family member	33.4%	4.2
Pashtun-speaking community (Vancouver, Canada)		Pashto / Dari	Video interpreter	44.1%	3.9
Balochi-speaking community (Manchester, UK)		Balochi / Urdu	Family member	28.6%	4.4

*Note.* Barrier severity was rated by patients on a scale of 1 to 5 where 1 = no barrier and 5 = very severe barrier. Interpreter access rate refers to the percentage of patients who received professional interpreter assistance when requested.

Table 5 gives a more in-depth view of Pakistani diaspora communities in the larger study sample. The languages of these communities include various dialects of the various languages spoken in Pakistan such as Punjabi, Urdu, Sindhi, Pashto, Balochi and Mirpuri, a dialect of Punjabi predominantly used by communities from Azad Kashmir. Some of these communities have significant differences in levels of interpreter access and in how the barriers were perceived in terms of their severity. The percentage of people who are able to access interpreters was somewhat higher among Punjabi speakers in Toronto (51.2%) possibly due to the larger and more established South Asian community in the city. The access of Urdu speakers was comparable in Birmingham at 55.7%, perhaps because Urdu speakers have been settled in Birmingham for a longer period and a more organized community advocacy may have taken place. Sindhi speakers in New York (33.4%) and Balochi speakers in Manchester (28.6%) had the lowest rates of interpreter access, and the highest severity scores for the barriers to accessing interpreters (4.2 and 4.4 out of 5 respectively). This phenomenon indicates that such is the case with smaller and more invisible linguistic minorities within the Pakistani community of the Pakistanis abroad. Many patients in these communities had used family members including in some instances children as interpreters, which poses serious ethical and clinical issues. Through the discourse analysis, it was found that family interpreting results in incomplete and inaccurate communication. The situation is particularly difficult for communities that are not well served by formal interpreter services such as Sindhi and Balochi speakers.



## Discussion

Results of this study will lend to robust evidence of language barriers as a crucial impediment in the process of equitable healthcare communication in multilingual societies. The study highlights the lack of linguistic equality in a variety of healthcare encounters in Canada, the United Kingdom and the United States, and illustrates that this is not an isolated issue but a systemic problem that impacts a significant number of LEP patients. The findings can be seen as an indication that linguistic resources play a significant role in the realm of health care communication, and that issues of access to effective communication should be considered a linguistic justice issue, not a practical one.

The first research question aimed to survey the prevalence of communication difficulty due to language barrier in the lives of LEP patients and to understand the extent of this difficulty in LEP patient's communication, particularly in the Pakistani diaspora communities. The results showed that 58.5% of patients surveyed had severe communication problems, in line with previous studies that have found a relationship between language barriers and poor quality of care and patient outcomes. The findings are consistent with those of Flores (2006), Bowen (2015), and Diamond et al. (2019) that patients who are not very fluent in the dominant language often have difficulty understanding a diagnosis, treatment options, and medical recommendations. The present study builds on these results by showing that communication problems remain regardless of differences in policy and institutional arrangements within the healthcare systems in different nations. The problem seems not to be specific to a country, but typical of healthcare systems in institutional environments in which the language prevailing in most contexts is monolingual.

One significant discovery has to do with the characteristics of the barriers. In addition to the highest percentage of reported communication problems being due to limited English proficiency, medical jargon was also a significant cause of communication problems. This means that patients with limited proficiency in English are not the only ones that have communication problems. People who speak English but not well, may have difficulty understanding specialized medical jargon. Linguistic justice, therefore, is not just about having provision of translation; it's also about communication that is accessible and intelligible. This is a confirmation of the importance of audience design and communicative accommodation in institutional discourse that are based on sociolinguistic perspectives.

The findings with respect to use of interpreters are among the most compelling findings in the study. Professional interpreter support patients felt significantly better about communication satisfaction, understanding of the diagnosis, treatment plans, trust in healthcare providers and compliance with follow-up instructions. The statistical significance of these differences shows that interpreter services do not just help to improve healthcare communication, they are integral to equal access to healthcare information. The results in this study are consistent with that of Karliner et al. (2007) who stated that professional interpreters are able to help patients achieve outcomes similar to native speakers of the dominant language.

Meanwhile, the results show a disturbing lack of need-satisfying provision. Only half of patients who needed to use an interpreter used one. This difference reiterates the institutional problems with communication needs for multilingual populations. This disparity is seen as being due to lack of trained interpreter, lack of resources and the use of family members or bilingual employees by healthcare providers in previous studies. The results of the current research support these concerns and show that the provision of interpreters remains inadequate in the delivery of high quality healthcare communication, despite the fact that this is recognised as being very important.

The discourse analysis provides additional understanding of the role of language barriers in interactional processes in clinical contexts. Patient hedging, clinician repetition, interrupted clinician's turn and minimal clinician's response were the factors that were significantly higher when patient-consultant communication was done without a professional interpreter. The results indicate that patients that communicate poorly might tend to have passive communication roles, thereby reducing their involvement in healthcare communication. The use of uncertainty markers is more frequent, suggesting less certainty in communicating health concerns, e.g. "I think" and "maybe". Likewise, the number of patients who answered with a few words suggests limited possibilities to discuss the symptoms, questions, and clarification that patients may have had.

Particularly important is one finding, that of the domination of the clinician in the consultations. The results of the study indicated that much more talk time was under the control of healthcare providers without interpreters. This pattern shows the ways in which language barriers contribute to and perpetuate power disparities in health care. Sociolinguistic studies of communication consider that it is not only a transmission of information but also negotiation of social relations and power structure. Without enough language skills to engage in conversations and discussions, patients' voices are constrained when it comes to decision making in care. Consequently, communication turns to be more and more clinician focused, and less patient focused.

The theory of linguistic capital of Bourdieu can help to understand these findings. Bourdieu (1991) describes language as a symbolic capital which can offer benefits in a particular social field. English competency is an important type of linguistic capital in the healthcare context, as it allows patients to comprehend medical language and effectively communicate their symptoms and illness to healthcare providers, as well as engage with institutional procedures. Limited English proficiency places patients in a disadvantaged position in the health care domain as they have less language capital. The results confirm this disadvantage in not only understanding but also in participating, satisfaction, and the quality of care received from health care providers.

On the other hand, the study corroborates Yildiz's (2012) notion of monolingual paradigm. In Canada, UK and USA, other languages are not a core element of the service delivery but mostly considered as second language, being the primary language used in healthcare institutions. The availability of interpreter services is still limited and the difficulties in communication reported by patients highlight the lack of integration of multilingualism in health care practice. As a result,

language diversity is generally seen as an aberration, not a normal aspect of settings such as today's health care system.

The results pertaining to the Pakistani diaspora communities also shed light on the problems of linguistic justice. The study shows that the Pakistani-origin patients are not a homogenous group of patients in terms of their linguistic characteristics. Rather they are from diverse background and language such as Punjabi, Urdu, Sindhi, Pashto, Balochi, Mirpuri etc. There were some important disparities in level of interpreter access and perceived barriers regarding interpreter severity across these groups. Larger and older communities (e.g. Punjabi and Urdu speakers) tended to have more professional interpretation services available. Conversely, smaller linguistic groups, such as Sindhi and Balochi speakers, indicated reduced access to interpreters and increased difficulties communicating with an interpreter.

The results provide a very clear reminder of the need for improvements in the way language is supported. Healthcare providers often simply think that providing services in Urdu language are enough for Pakistani origin populations. But the findings show that such assumptions fail to understand that there is linguistic diversity within the Pakistani diaspora as well. It's a combination of marginalization if you will, of minority language speakers being marginalized in the broader health care system and in the language support plans created for their own ethnic groups.

The results overall enrich literature in the field of health communication, sociolinguistics and linguistic justice. They show that language barriers are tightly connected to power, participation and equity issues. The study demonstrates that professional interpreter services play a significant role in enhancing the communication process, but at the same time some systemic inequalities still exist in accessing professional interpreters. The study explores the linguistic capital theory of Bourdieu, and draws on the experiences of different Pakistani diaspora groups in three countries to gain a deeper understanding of the role of language as a communicative tool and as a tool of social inclusion/exclusion. Finally, the results confirm that in order to ensure equitable healthcare, it is necessary to take into account the linguistic accommodation of patients as well as the need for structural approaches which view multilingual communication as an integral part of quality healthcare services and delivery.

### **Conclusion**

This study aimed to explore the role of linguistic justice in multilingual healthcare contexts in Canada, UK and the USA and specifically in the context of Pakistani diaspora communities. The results are not only clear, but troubling. In these areas the majority of patients with limited English proficiency have language barriers. Results from professional interpreter services can really enhance the quality of communication, patient understanding, and satisfaction. However, over half of the patients who were required to get an interpreter did not. The discourse analysis revealed that a clinical conversation is dominated by the clinician, a patient has limited capacity to express his or herself, and meaningful communication fails, if there are no interpreters.

These findings can be understood by the concept of linguistic capital that was developed by Bourdieu. If patients do not speak English they have a lack of linguistic capital in the health care sector. It's not their own fault. It is the effect of being raised in a society that has been created with a set of one language and a single cultural standard. In her work, the monolingual paradigm in healthcare, described by Yildiz (2012), assumes that English is the natural and normal mode of communication in healthcare contexts and all other languages are outsiders that need to be managed or accommodated in healthcare settings. This study asserts that this is not just. All patients, no matter their language, deserve to be educated about their diagnosis, treatment and

directions for medications. This is not a luxury, it's a necessity. This is a fundamental aspect of safe health care.

The results of the Pakistani diaspora communities is particularly relevant. The country of Pakistan is a language rich nation which has plenty of regional languages. There are a number of people in Pakistan who come to the western countries with languages which are not often used on rosters of interpreter service providers. Many Pakistanis, especially from small language groups (Sindhi, Balochi), come to the western countries with languages that are not on the rosters of interpreter service providers. Although they might not be very proficient in Urdu, they are usually classified in the same category as Urdu speakers. This makes it to be a double invisibility. As they are already linguistically marginalised in the country they live in, they are also marginalised within their own community of patients from the Pakistani diaspora when the services offered assume Urdu is adequate for all Pakistani patients.

The findings of this study have policy implications. In Canada, the UK and the USA, hospitals and health systems must take action and seriously invest in professional interpreting services and make them available – not just available in theory. Healthcare workers must be trained in interpreting—not only in the process—but in the importance of language justice, and how their communication practices can enhance or exclusion patients. Health systems must go beyond providing a "one size fits all" language services to understanding the linguistic diversity among communities, such as the Pakistani community. Technology, such as video interpretation, may be helpful in reaching speakers of less common languages, if it is appropriately funded and utilized in the course of normal clinical practice.

Limitations of this study need to be recognised. Although the data is reported from six hospital locations, these were selected to be representative, this data does not reflect the experience in every health care location. Data from the survey is self-reported by patients and can, therefore, suffer from social desirability bias. The clinical transcripts (CT) were fairly large but were from particular departments and do not necessarily reflect all kinds of clinical encounters. The corpus should be extended in terms of settings, type of clinical encounters and languages. Longitudinal studies of the same patients over time would also provide great insight of long term health consequences of language barriers.

To sum up, the present study is a clear contribution of the literature as it is conducted by the combination of corpus-based discourse analysis and a sociolinguistic approach of language justice, and by introducing the unique experiences of the Pakistani diaspora communities in the field of cross-national comparisons. The findings show that health literacy issues of language are not just a logistical problem, but a systemic injustice and therefore a systemic solution is needed. As any language is an integral part of a healthcare system that aims to deliver quality care to all patients, it's not something to be taken for granted. Beyond localized clinical interactions, the systematic marginalization of vulnerable populations is structurally reinforced by institutional discourses that prioritize authoritative voices over the lived experiences of minoritized groups (Mumtaz Hussain et al., 2026). Deconstructing these power asymmetries in public media frameworks highlights the critical need for more inclusive, socially accountable models of communication across both environmental and institutional healthcare domains.

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