Foreword

Building a Resilient, Pluralistic Community through Knowledge Production

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> Equity and justice are public health issues. Without addressing structural injustice in our systems and institutions, we will continue to view marginalized populations as deviants and ills of our society—when the truth is, the suffering and disparities of vulnerable populations are the symptoms of an ill society that has failed to maintain a just and fair system for all its citizens. (Hsieh and Kramer 2021, 433)

Social Sciences, including Communication, have become critical and reflective of the process and outcomes of knowledge production. A study of publications during 2006–2010 in high-impact journals in developmental psychology found that WEIRD participants (i.e., participants who are Western, Educated, and from Industrialized, Rich, and Democratic countries) account for 90.52 percent of the research subjects from whom claims were extrapolated and generalized (Nielsen et al. 2017). #CommunicationSoWhite highlighted activism among communication scholars to reflect how communication as a discipline has evolved in a way that marginalized non-White voices. In particular, Chakravartty et al. (2018) found:

> Non-White scholars were virtually absent in journal publications as recently as the 1990s. Non-White authors in these publications, however, increased to 6% by the end of 1990, and 12% by the end of 2010. In general, non-White scholars are underrepresented among the published first authors in communication journals, authoring only 746 out of 5,262 (14%) documents published from 1990 to 2016. (259)

They further argued,

> Knowledge production that reinforces Whiteness as its undisputed, unexamined frame is incapable of asking what we might learn from the experiences of those

> who have been, for decades if not centuries, is possessed of their lands, policed, bombed, detained, indebted, and rendered illegal. (262).

Through such an understanding, #CommunicationSoWhite shifts its focus from the race of authors to a call for action for new approaches to knowledge production. Many researchers, White and Non-White, have worked to create inclusive dialogues and spaces that recognize and welcome diverse perspectives and approaches to communication. Many Non-White scholars have also have taken it upon themselves to participate in infrastructure-building and community-building. As researchers and practitioners (re)imagine knowledge production that does not reinforce Whiteness, new possibilities and research questions emerge.

This book embodies health communication scholars' efforts to identify, investigate, and explore the experiences of migrants, immigrants, and ethnic minorities—groups that are often vulnerable and marginalized in a host society. Editors and authors have embedded themselves in these populations and communities to challenge, extend, and broaden the landscape of communication scholarship.

These vulnerable populations are often targets of racism. In the increasingly globalized world, "go back to where you are from" or "go back to your country" are still casually and hurtfully tossed out to mark a person's outsider status in many societies, aiming to inflict pain and alienation. "You don't belong"—regardless of how successful you are or how long you have invested in the host society. As Trump gears up for his re-election campaign in 2024, he urged the crowds in New Hampshire:

> [Undocumented immigrants] are poisoning the blood of our country. That's what they have done. . . . They poison—mental institutions and prisons all over the world. Not just in South America. Not just the three or four countries that we think about. But all over the world they're coming into our country—from Africa, from Asia, all over the world. (Black 2023, para. 4)

Despite the demographic diversity and long histories of migrants, immigrants, and ethnic minorities in the United States, their cultural values, normative practices, and illness ideologies are often viewed as irrelevant, if not treated as a nuisance, in clinical settings where Western Biomedicine dominates. When I first started my research on language barriers in healthcare settings in the early 2000s, I interviewed healthcare providers to understand the barriers to these vulnerable populations' access, process, and outcomes of care. One emergency room physician explained, "When a patient does not speak English, I become a vet. I poke, and they yelp. That's how I get my diagnosis." Despite the legislative mandate for equitable, meaningful language access in

healthcare settings, many healthcare providers continued to believe that it is a patient's responsibility to learn English. However, the language barrier is only one of the most obvious challenges a language-discordant patient faces because these patients often face disparities in medical knowledge, institutional power, and access to resources in healthcare settings. In *The Spirit Catches You and You Fall Down*, Fadiman (1997) detailed how miscommunication between healthcare providers trained in Western Biomedicine and Hmong parents of a child with epilepsy resulted in a neurological crisis that rendered the child in a persistent vegetative state.

Culture and cultural perspectives are foundational in shaping immigrants', migrants', and ethnic minorities' understanding and practices of health and illness (Hsieh 2022). In addition, these perspectives are contextually situated in the host society/community (see also Hsieh and Kramer 2021). Host community-patient dynamics is intertwined with patients' access, process, and outcomes of care. Depending on the social, cultural, and historical contexts of the host community, a patient's language, culture, and race may shape their healthcare experiences. For example, although language-discordant patients are often perceived to be part of the vulnerable populations susceptible to discrimination and marginalization in healthcare settings, this is not necessarily the case for all patients (Terui and Hsieh 2022).

Language barriers do not mean the same thing for language-discordant patients, even when they are in the same host community or speak the same language. For example, in Taiwan, a German-speaking patient is more likely to receive privileged status than an Indonesian-speaking patient (Lan 2011). Similarly, in the United States, a White patient from Spain is unlikely to have the same healthcare experiences as a Non-White patient from Guatemala, even though both speak Spanish. When reviewing the impact of the Civil Rights Act of 1964, Rose (2014, 211) concluded, "Language is not race-neutral. It is race laden." For some patients, their language-discordant status signals their privileged status and compels the locals to accommodate. In contrast, others may find language barriers making them vulnerable to hidden discrimination and health disparities, requiring them to adopt unique strategies to negotiate their agency and power in a hostile environment (Canagarajah 2013).

This book investigates the unique, contextually situated experiences of the cultural Other. This book is poignant in a post-pandemic world when the meaning of fairness and justice for all demands real-life applications. By recognizing the challenges faced by migrants and the acculturation pressure in the host society, the authors explore how the migrants negotiate their cultural perspectives and adopt strategic actions as they navigate a complex healthcare system in a potentially hostile host society. "Minorities' distrust of government and healthcare providers not only reflects their marginalized status in society, but often reflect the chronic struggle and tumultuous histories

they share with the dominant groups" (Hsieh and Kramer 2021, 172). Rather than attributing migrants' experiences of health disparities to their "problems" (e.g., lack of health literacy and acculturation), the authors eloquently and collaboratively provide a complex and comprehensive understanding of host community-patient interdependence. These cultural Others demonstrated resourcefulness, resilience, and ingenuity as they integrated their cultural self into the host society through healthcare practices.

In addition, by examining the different ways a host community can reach out and connect with vulnerable populations that strengthen the cultural Other's agency while integrating them into the larger society, the authors explored the possibilities and pathways for a host society to co-evolve with its vulnerable populations. At its core, community-based participatory research and interventions do not aim to transform or "improve" the marginalized populations—rather, these are community efforts to give voice and allow access to the cultural Other to build a fair and just system *together*.

Readers of this book will be delighted to see the dialogic spaces created and the dialogues generated through these chapters. Knowledge production, as well as a fair and just social system, is a never-ending process. As a society welcomes cultural Others, be it war refugees, LGBTQ+ groups, or immigrants "all over the world," a healthy, vibrant, and resilient society co-evolves with its citizens. As cultural Others participate in the dialogues of community-building, they become part of the infrastructure, the core. New cultural Others emerge. The dialogues continue. An inclusive process of knowledge production allows all to thrive in their communities from one generation to the next.

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