According to the 2000 US Census, there are more than 46 million people in the United States who do not speak English as their first language. Furthermore, 21 million of these people speak English less than “very well”. This was a 42% increase from the prior Census. For these residents, there are very few medical services that are able to provide bilingual healthcare providers in practice. As a result, the majority of providers rely on other providers, medical staff, and untrained translators to converse with their patients, despite the laws that are in place requiring linguistic access. Title VI of the Civil Rights Act of 1964 requires that persons with limited English proficiency (LEP) have access to bilingual tools to aid them in health services. Unfortunately, these laws are not frequently enforced due to the cost and the difficulty of providing this service depending on the size or patient mix of the health care entities. Consequently, many patients in the healthcare field are questioning how the medical field should approach language barriers, or if it is even possible to approach the issue at all.

Multiple articles demonstrate that LEP patients are less likely to receive the medical care they need. These studies found that, compared with English speakers, people who do not speak English as their primary language are less likely to become insured, receive preventative care, or have a primary care physician. This may be a result of a lack of income to become insured or cultural differences within the Latino community. This population is less likely to schedule follow up visits and adhere to directions from their medical professionals compared to patients who have proficient English skills. Lastly, LEP patients are less satisfied with the treatment they do receive. Medical professionals also report they are less satisfied with their patient interaction when they face a language barrier (Homerberger, Itakura, and Wilson 1997).

Language barriers strongly affect LEP patients in their access to health care, adherence and understanding of the care they are receiving, quality of care, and the patient-provider satisfaction. Not all studies account for possible confounding variables. More research needs to be conducted to explore these hypotheses to determine if the language barrier is truly the culprit of these disparities.

Conclusion and Future Recommendations

As the Latino population in the United States grows rapidly, the language barrier is becoming increasingly prevalent. The United States institutes the use of translator telephones so that way doctors can communicate with their patients. While this does help, a lot is lost in translation and this medium removes a lot of the humanistic aspects of medicine that are the cornerstone of good medical practice. By not being able to communicate properly with one’s patient, a provider has a harder time comforting them and forming a relationship. As a result, LEP patients are less likely to feel safe or comfortable while receiving medical care and to seek medical care when they do actually need it. Lastly, this skepticism and lack of comprehension of treatment leaves this LEP population more vulnerable to adverse reactions than non-LEP populations.

Bilingual providers are in extreme demand. Translators can be utilized (though not always readily accessible), but there are many issues when it comes to maintaining a personal relationship with patients. While it is not feasible to have every provider learn the Spanish language in order to resolve this issue, it is important that providers recognize that these issues are important considerations to incorporate into their own evidence-based practice. Language intervention workshops have proven to reduce the effects of a language barrier. It is essential that an emphasis is put on multilingual education in healthcare so that providers are able to bridge this gap and accommodate their patients.

This research helped me solidify my passion for helping bridge the gap between Spanish-speaking patients and medical providers. By continuing my education in the medical field while studying Spanish, I will be able to administer more personable care to an entire population that many professionals are not able to give. I will be providing for a Fulbright Grant for 2020-2021 in order to investigate more about the language barrier and see how it relates to cultural differences. Hopefully by learning more about the Spanish culture in terms of healthcare first hand, I will be able to apply my knowledge to my evidence-based practice when I become a medical professional.