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Mini-Review

The Silence Between Languages

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When I first went to evaluate my patient on the medical floors, I expected a routine post-stroke encounter. He was a 31-year-old Spanish-speaking male with history of uncontrolled hypertension and HFrEF who had been admitted for an acute CVA. According to the chart, he initially presented with left-sided facial droop and right upper extremity numbness. When I entered the room and introduced myself, he smiled politely and nodded. I asked if he was feeling better, and he quietly responded, "yes." It quickly became apparent that there was a significant language barrier, so I told him I would call interpreter services before continuing the interview. Once the translator joined the conversation, I asked whether he had developed any new weakness or numbness. He hesitated before explaining that his left arm had begun to feel "strange." On examination, I found profound weakness of the left upper extremity, with 0/5 strength in both proximal and distal muscle groups, a finding that had not been documented in prior notes. When I asked him when this weakness began, he stated that it had started sometime overnight. I then asked whether he had informed anyone about this new deficit. He calmly replied that he had not called for help. At the end of the encounter, I reminded him to immediately use the call bell if he noticed any new symptoms or neurologic changes. Yet the question stayed with me for the rest of the day: how had a new focal neurologic deficit gone unnoticed for nearly fourteen hours? Was it because nobody specifically asked? Was it because communication had been reduced to brief yes-or-no interactions due to the language barrier? Or was it because he himself hesitated to report worsening symptoms in an unfamiliar healthcare system where he could not easily communicate? I could not stop thinking about how much may be lost in translation every day in medicine, particularly during time-sensitive emergencies such as stroke care.

Stroke evaluation depends heavily on accurate communication between patients and healthcare teams. Much of the urgency surrounding diagnosis and treatment relies on understanding symptom onset, progression, and subtle neurologic changes. Prior studies have demonstrated that patients facing language barriers experience measurable delays in acute stroke treatment. One retrospective study found that non-English-speaking patients had significantly longer times from symptom onset to thrombolytic therapy, including delays between imaging and treatment administration, ultimately contributing to worse neurologic outcomes [1]. In diseases such as acute ischemic stroke, where minutes directly affect neuronal survival, even small communication delays may carry profound consequences. Language barriers may also influence outcomes long after the acute treatment window closes. Research published by the American Heart Association demonstrated that patients with language barriers were more likely to leave the hospital with moderate-to-severe neurologic deficits compared with English-speaking patients [2]. While many factors likely contribute to this disparity, one possibility is that subtle changes, evolving symptoms, and patient concerns may be less likely to surface when communication is fragmented or inconsistent. Another important aspect of this issue is the emotional isolation experienced by patients with limited English proficiency.

Qualitative studies examining hospitalized non-English-speaking patients describe language barriers as a persistent source of loneliness, anxiety, and vulnerability throughout hospitalization [3]. Many patients reported becoming accustomed to incomplete communication and accepting poor translation or misunderstanding as a normal part of medical care. Participants also described fear surrounding medical errors, difficulty understanding consent discussions, and discomfort speaking up when something felt wrong [3]. Over time, this normalization of miscommunication may lead patients to underreport symptoms, avoid asking questions, or remain silent even when their condition changes.

In many ways, I wonder whether this dynamic contributed not only to the delayed recognition of my patient's worsening deficits, but perhaps even to the stroke itself. Despite prior hospitalizations and discharge on GDMT for hypertension and heart failure, he admitted that he had fallen out of follow-up and was not compliant with medications because he did not fully understand the severity of his illnesses. Studies have consistently shown that individuals with limited English proficiency face reduced access to preventive

care, increased rates of hospital readmission, and a higher risk of adverse healthcare outcomes overall [4]. Communication barriers do not simply complicate isolated hospital encounters, they can shape the trajectory of chronic disease itself. I still think about this encounter and how easily silence can be mistaken for stability in medicine. A patient who nods politely may still be confused, afraid, or deteriorating. And I wonder how many other patients quietly experience worsening symptoms in hospital rooms while the healthcare system mistakes the absence of words for the absence of problems.

References

1. Meyer (2021) Disparities in Care and Outcome of Stroke Patients from Language Barriers. Journal of Clinical Medicine 2021.
2. Kilkenny (2015) Impact of Language Barriers on Stroke Care and Outcomes. Stroke, American Heart Association 2015.
3. Molina (2023) A Multi-Language Qualitative Study of Limited English Proficiency Patient Experiences in the United States PEC Innovation 2023.
4. Al Shamsi (2016) Identifying and Preventing Medical Errors in Patients With Limited English Proficiency. BMJ Quality & Safety/PMC Review Article 2016.