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Is English-Language Proficiency Really A Barrier With Foreign-Trained Physicians?

Concern about English-language proficiency should not block reforms that enable qualified physicians to practice medicine.

Jared Rhoads

A growing number of state legislatures are considering proposals that would create alternative licensure pathways for experienced foreign-trained physicians. These bills would allow physicians with substantial clinical experience abroad to practice medicine in the United States without repeating the full, multi-year residency training process. Thousands of qualified physicians already living in the United States are currently unable to use their skills due to the cost, length, and rigidity of the standard re-entry pathway. This is a substantial underutilization of human capital. State proposals to fix this vary in their details, but most bills feature a layered approach involving verification of credentials, some form of a requirement of demonstrated clinical competency, and some form of employer sponsorship or supervised practice.

Often the question of English language proficiency arises during hearings and committee meetings. Legislators wonder whether a physician trained abroad who speaks English as a second language can communicate effectively enough to deliver safe, high-quality care. Recognizing that medicine depends on clear communication and that a misunderstood symptom, ambiguous instruction about medication dosage, or failure to convey a serious diagnosis can have real consequences for patients, these questions sometimes hinder or delay action.

When this concern is examined in the context of all the various checks and balances that are in place, combined with the additional checks and balances that these bills typically include, it does not appear to justify delaying or blocking the broader reform effort.

What the Literature Shows About Language Barriers in Healthcare

A substantial body of literature documents the negative effects of language barriers on healthcare outcomes. Patients with limited English proficiency (LEP) experience higher rates of adverse events, longer hospital stays, lower satisfaction, and greater difficulty understanding discharge instructions and medication regimens.[1] A systematic review by Karliner, et al., found that professional interpreter services significantly improved clinical care for LEP patients, including better comprehension, fewer errors, and greater adherence to treatment plans. Relatedly, in a small study involving pediatric encounters with LEP families, Flores and colleagues documented that errors in medical interpretation are common, and that communication errors were more

likely to have clinical consequences when professional interpreters were absent.[2] A later study by Flores, et al., found that the use of trained interpreters reduced the rate of clinically significant medical errors by a substantial margin compared to ad hoc or no interpretation.[3]

These findings are important, but they describe a specific problem: the difficulty faced by *patients* who cannot communicate fluently in the language of the healthcare system. The question before legislators is a different one. It is whether *physicians* who are non-native English speakers—but who have demonstrated sufficient English proficiency to pass rigorous licensing examinations and function in English-language clinical environments—pose a comparable communication risk.

On the question of *physician* language proficiency, the situation is different. Research on foreign-trained physicians practicing in the United States has generally found that their clinical outcomes are comparable to, and in some studies slightly better than, those of U.S.-trained graduates. For instance, a widely cited study published in *The BMJ* by Tsugawa, et al., analyzed outcomes for Medicare patients treated by foreign-trained physicians versus U.S. graduates and found that patients of foreign-trained physicians had slightly lower 30-day mortality rates and comparable readmission rates.[4] While this study did not isolate language proficiency as a variable, its findings are difficult to reconcile with the hypothesis that non-native English-speaking physicians are systematically delivering inferior care.

Other studies have focused on language concordance, which refers to situations where a physician and patient share a native language. These studies show benefits including higher patient satisfaction, better self-management of chronic conditions, and improved adherence. Research by Ngo-Metzger, et al., found that language concordance was associated with better interpersonal care and greater patient understanding among Asian-American patients.[5] Similarly, Fernandez, et al., found that Spanish-speaking patients reported better experiences when treated by Spanish-speaking physicians.[6] If anything, this corner of the literature forms argument in favor of linguistic diversity in the physician workforce, not against it.

Existing Safeguards Are Robust

The concern that a physician with limited English fluency might slip through the licensing system underestimates the checks and balances already in place. Most state bills require applicants to possess basic fluency in English as demonstrated by a passing score on the occupational English test for medicine or an equivalent examination. More to the point, the United States Medical Licensing Examination (USMLE), which all physicians must pass to obtain licensure, is administered entirely in English, and there are no non-English options. Clinical vignette questions involve interpreting patient narratives, symptoms, and chart information in English.

Beyond exams, the clinical training pipeline itself functions as a sustained English-proficiency evaluation. Most state bills of this type include some period of supervised training at an in-state healthcare facility or require an offer for employment as a physician at such a site, which places the foreign-trained physicians either under direct observation or in a

context in which they are in close professional contact with other team members. For instance, Vermont Senate Bill 142, currently under debate, requires two years of supervised practice. New Hampshire Senate Bill 457, also currently under debate, requires an offer of employment. This is in line with laws enacted in Wisconsin, Arkansas, Indiana, Nevada, Oklahoma, and elsewhere.

Other checkpoints already embedded in our system make the language issue self-regulating in other ways. Hospital credentialing processes, employer hiring decisions, the process of securing malpractice insurance, and ongoing peer review provide additional layers of filtering and opportunities for evaluation. In a professional work environment with colleagues where there is constant teamwork and documentation taking place, communication failures surface quickly, allowing intervention to occur if appropriate.

Relation to Physician Supply Issues

A shortage of between 13,500 and 86,000 physicians by 2036 has been forecasted by the Association of American Medical Colleges, affecting patients everywhere.[7] Allowing qualified foreign-trained physicians to practice their profession helps patients and physicians alike. For some patients, the alternative they face to having a native English-speaking physician is having no physician at all. Meanwhile for physicians, licensing reform means the ability to put their skills and human capital to use, and to earn a living as a medical professional, which is good for them, their family, and their community.

Communication plainly does matter, but the possibility of inadequate physician-side English proficiency affecting care in rare or isolated cases does not justify maintaining barriers that keep qualified physicians out of practice. Foreign-trained physicians who have passed English-language licensing examinations, completed or demonstrated equivalence to U.S. clinical training, and satisfied credentialing requirements have already cleared multiple, overlapping assessments of their ability to function in English. Their ongoing clinical work subjects them to continuous, real-world evaluation that no written test can replicate.

Although it may be reasonable to raise a question about English proficiency, there is no systematic trend demonstrating that limited English proficiency among foreign-trained physicians harms patient outcomes or presents a unique risk to patients. While absence of evidence is not evidence of absence, if this were a widespread problem, we would expect to see reports of it more prominently in the literature. Without stronger evidence of harm, there appears to be little justification to allow this concern to hold up policy efforts.

About the Author

Jared Rhoads is Executive Director of the Center for Modern Health. Email address: jared.rhoads@centerformodernhealth.org.

Declaration of Conflicting Interests

The author has declared no potential conflicts of interest with respect to the research, authorship, or publication of this article.

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