Perceptions and Experiences of Emergency Medical Care Among Spanish-speaking Latin American Immigrants in Providence

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ABSTRACT

BACKGROUND: Latin American immigrants experience disparities in health care access and quality. Many underutilize emergency medical care, but some may overuse emergency departments as safety nets.

METHODS: This qualitative study used semi-structured interviews to understand Latin American immigrant experiences with emergency medical care. Thematic analysis and grounded theory were used to uncover recurring concepts.

RESULTS: The 15 Spanish-speaking Latin American participants generally understood that emergency medical care was for life-threatening conditions. Friends and family were major sources of information about accessing healthcare. Barriers to emergency medical care included high cost, long wait times, and lack of knowledge about the healthcare system. Some participants increased emergency medical care utilization once in the United States because of increased quality of care, while others decreased utilization because of high costs.

CONCLUSIONS: Latin American immigrants face many barriers to emergency medical care. Avenues of reform include expanding free clinics and employing social networks to spread information about the healthcare system.

KEYWORDS: emigrants and immigrants; health status disparities; emergency medical services; health knowledge, attitudes, practice; Hispanic or Latino

INTRODUCTION

Approximately 44% of all United States (US) immigrants come from a Spanish-speaking country, particularly in Latin America.[1] Most Latin American immigrants (56%) have annual household incomes of less than $40,000, and 26% are uninsured.[2] Lacking insurance may prevent people from having a regular primary care doctor, thus increasing the reliance on emergency departments (EDs) as a safety net that will accept patients regardless of insurance status.[3-5] Indeed, Latin American patients are more likely to visit the ED for chronic conditions that require outpatient management.[6-8] However, overall, immigrants may still utilize EDs less (10.6%) when compared to US-born Americans (14.7%).[9] Language discordance, low income, and a fear of discrimination can also act as significant barriers to healthcare. These challenges are especially important to consider given the higher rates of diabetes, HIV, end-stage renal disease, liver disease, certain types of cancer, and other conditions among Latin Americans in the US.[10,11]

Qualitative studies exploring the reasons behind Latin American immigrant trends in emergency medical care use – including both ambulance and ED use – have focused on specific subpopulations or barriers as opposed to capturing a complete narrative.[12-14] This study aims to build on previous studies by filling the gap in knowledge about how Spanish-speaking Latin American immigrants perceive and utilize emergency medical care in the US, especially in the context of barriers to care and previous experiences in home countries. There is also a lack of research about the specific experiences of Latin American immigrants in a New England context. This is especially important since nearly one-fifth of Providence, Rhode Island (RI) residents identify as Latin American and 13% of all households speak Spanish at home.[15,16] There are seven neighborhoods with over 50% Latin American residents, and poverty levels in these areas range from 15% to 42%.[17,18] This study can guide reform to improve how healthcare is delivered to Latin American immigrants.

METHODS

Semi-structured in-depth interviews were conducted in November and December 2024 with Spanish-speaking Latin American immigrant adults >18 years old who were recruited in Providence, RI. The researcher in charge of recruitment, interviews, and analysis was a male college student who had been an emergency medical technician in Providence for over two years and is fluent in English and Spanish. Two additional physician-researchers reviewed all materials and analyses.

This study used a maximum variation, purposive, convenience sampling technique in that Latin American immigrant adults were non-randomly selected with substantial effort to recruit people across different ages, genders, and countries of origin. Recruitment was conducted until saturation outside Latin American restaurants and markets. Potential participants were screened face-to-face and invited

to participate in a 30-minute interview, which took place in participants' homes, on Zoom, or in public parks with no other people present. Participants were provided with consent forms explaining the study in detail, including potential risks and benefits. An interview guide was pilot-tested in advance. Participants were compensated with a $15 gift card.

Interviews were audio-recorded and transcribed using online transcription services. A bilingual researcher confirmed transcription accuracy and analyzed the data in Spanish using NVivo software and an iterative grounded theory approach.[19,20] This study followed the consolidated criteria for reporting qualitative research.[21] This study was reviewed and exempted by the Brown University IRB.

RESULTS

Of the 63 people that consented to being contacted to schedule an interview, 15 (23.8%) completed the interview. Most non-responders cited not being interested or having enough time. Participants were predominantly middle-aged, non-Black, working class adults that knew little English and held degrees of higher education; specific demographics data are broken down in **Table 1**. The amount of time spent living in the US ranged from one month to 26 years and all but two participants were from either the Dominican Republic or Guatemala. The sample was roughly split between men and women, those who did and didn't have insurance, and those who did and didn't have primary care physicians. All participants had utilized an ambulance or emergency room in the past and most had done so in the US. Representative quotes for each interview theme are displayed in **Table 2**.

I. Beliefs About What to Do When Sick or Injured

When asked what they do when they become sick or injured, many participants – mostly men – said they first try to resolve the issue at home using over-the-counter medication, rest, or natural remedies. Several participants relied heavily on healing at home and resisted seeking medical care. Other participants felt that if they didn't feel better after a few days, they would then seek medical care, often at a community health center or free clinic.

Emergency medical care was seen as appropriate for situations that were severe, life-threatening, and persisted for a long time, but interpretations varied. One participant with insurance explained that "when I called the ambulance for my son, I saw that I couldn't lower his fever…the best option was to call 911." On the other end of the spectrum, a different person without insurance waited 15 days with metal stuck in their eye before going to the hospital.

The most common reasons for calling an ambulance were loss of consciousness or cardiovascular symptoms. Stories involving visiting the emergency room without an ambulance were more common and varied. Several people vaguely cited "not feeling well" as a reason to seek emergency medical care. Three people reported seeking emergency medical care for a chronic condition.

II. Sources of Information About the US Healthcare System

Most participants said they learned how to utilize the US healthcare system from friends or family members. One participant emphasizes the importance of social networks, stating that "in reality, it's guidance from people. We are in an area with many Dominicans. You ask and they tell you."

Table 1. Demographic and health-related characteristics of participants

Participant	Gender	Age	Ethnicity	Country of Origin	Education Level	Primary Language	Insurance	Have Primary Care Doctor	Use Medical Translator
1	Man	62	Latino	DR/PR*	Associates	Spanish	Public	Yes	Yes
2	Woman	43	Latina	DR	Bachelors	Spanish	Public	Yes	Yes
3	Woman	45	Afrolatina	DR	Masters	Spanish	None	No	Yes
4	Woman	42	Latina	DR	Bachelors	Spanish	Private	Yes	Yes
5	Woman	27	Afrolatina	DR	Associates	English	Private	Yes	No
6	Woman	46	Latina	DR	Bachelors	Spanish	Public	Yes	Yes
7	Man	53	Latino	Mexico	High school	Spanish	None	No	Yes
8	Woman	47	Latina	DR	Bachelors	Spanish	Public	Yes	Yes
9	Woman	48	Latina	Guatemala	Bachelors	Spanish	None	No	Yes
10	Woman	50	Latina	Guatemala	Associates	Spanish	None	Yes	Yes
11	Man	58	Latino	Guatemala	Bachelors	Spanish	None	Yes	Yes
12	Man	42	Latino	Guatemala	High school	Spanish	None	No	Yes
13	Man	60	Latino	Venezuela	Doctorate	Half and half	Private	Yes	No
14	Man	38	Latino	Guatemala	High school	Spanish	None	No	Yes
15	Man	40	Latino	Guatemala	High school	Spanish	Private	No	Yes

*DR = Dominican Republic, PR = Puerto Rico. Participant 1 spent 13 years in DR and 23 years in PR. PR is not a country but is still part of Latin America.

Table 2. Interview theme results

Interview Theme Results	Representative Quotes
Beliefs About What to Do when Sick or Injured	
Healing at home	My first try is home medicine…going to the doctor is like a second option.
Health clinics	When I didn't have insurance, I went to find a clinic where they provided health care to immigrants. With a modest price, with low prices.
Situations that require emergency medical care	If it's something critical, a heart problem or something that is not within my means.
Sources of Information About the US Healthcare System	
Friends or family members	In reality, it's guidance from people. We are in an area with many Dominicans. You ask and they tell you.
Health care centers	When I went to the emergency room, I began to know what the hospital is.
Media	The number 911 is famous. Including in my country, you see it in the movies.
Barriers to Accessing Emergency Medical Care	
Medical care costs	If they don't have insurance, they're scared to go to the doctor because they'll receive an expensive bill.
	If it were an emergency, I'd have to go, knowing the cost is too much. I would have to do it for my health.
Emergency room wait times	They made me wait. Once in the ER, you know, it's hours and hours.
Lack of knowledge	Lack of knowledge. Until a few months ago, I learned the difference between urgent care, a clinic and a hospital, an emergency room.
Language barriers	When the doctors say medical terms, I don't understand them. That's why I ask for help.
Quality of care	I think that it was very good attention. They immediately put me some medicine to reduce the pain.
Discrimination	It's not the same when you have been here, you speak the language, you have health insurance.
Comparison of US and Home Country Emergency Medical Care Experiences and Perceptions	
Differences between healthcare systems	It's a Third World country, so they don't have as many resources, nor do they have the same facilities.
Changes in utilization and perception	Now being here, it changed completely, in the sense that I don't want to get sick and I take care of myself to not fall. Because I know that if I go to a hospital, a really expensive bill will come.
	I still have that habit, that [when] there are things you can't solve, you have to go to the emergency room.

A few participants cited learning how to navigate the healthcare system at health clinics or the hospital, especially health centers that provide free healthcare tailored to Latin American immigrant populations. Three participants stated they learned to call 911 for medical emergencies by watching TV, and no participants mentioned looking for information online.

III. Barriers to Accessing Emergency Medical Care

Medical Care Costs

Almost every participant stated that they view emergency medical care as very costly, even with payment plans. Roughly half of them perceived not having insurance or not having a good enough insurance as major barriers. Half of the participants mentioned that because of expensive bills, they actively avoid the emergency department except in extreme emergencies. As one participant explains it, "I've felt unwell, but I say, why would I go?…I don't have enough to pay for that. I have to pay rent, my food. Help my parents."

Many participants that reported not having issues paying for emergency medical care cited their insurance as making bills more affordable. Some uninsured people felt that even if a bill was high, they didn't feel bad paying it because they were able to receive the medical care they needed. For example, one person said, "Here, even though you may not have medical insurance, they don't deny you care." Other participants do not perceive costs as a significant barrier because they almost exclusively rely on free clinics or discounted rates.

Wait Times

All participants commented on long emergency room wait times, usually negatively. Two people said they left the emergency department after waiting for several hours

without being seen. On the other hand, participants' perceptions towards ambulances were more unified and positive. People appreciated how quickly ambulances arrived and assessed patients.

Lack of Knowledge

Several participants mentioned their lack of knowledge about the US healthcare system as an issue when determining what to do in a medical emergency, especially when they were newer to the country. Although everyone knew how to call for an ambulance, understanding when they should use urgent care, clinics, and hospitals was confusing for some. It was also a surprise to some just how expensive emergency medical care was. As one participant explains after receiving a bill of $1,000 for an ambulance ride they were unable to pay for, "I thought they should have told me, 'look, an ambulance will be called, but you will be charged."'

Language Barriers

When asked what language they use most in their daily life, 13 participants said Spanish and indicated that they need interpreters when accessing medical spaces. Most interpreter experiences were positive, with participants feeling grateful for the widespread availability of interpreters in emergency rooms. However, not all participants were fully satisfied with the interpreters they've encountered. "They may be translating, but perhaps they are summarizing… I could say a ton, and the translator tells [the doctor] a little bit," said one participant, echoing a sentiment shared by a few participants that information may get lost in translation.

Quality and Equity of Care

The quality of care provided in emergency contexts was regarded highly by a majority of the participants. Their general perception was that emergency medical providers were friendly, efficient, skilled, and comprehensive. Although a few people acknowledged that discrimination can happen, most of them have not had such experiences.

Still, 33% of the sample mentioned experiences with low quality care. Symptom invalidation, misdiagnosis, short interactions, and the doctor's inability to find any adequate diagnosis were all factors that tainted experiences in the emergency room. Similarly, 33% of the sample had experienced discrimination in medical contexts for their Latin American identity, immigrant status, insurance status, or limited English abilities. Examples of such unequal care included rudeness, longer wait times, feeling invalidated, and in one instance, refusal of care entirely.

IV. Comparison of US and Home Country Emergency Medical Care Experiences and Perceptions

Most people agreed that US emergency medical care costs more, produces shorter wait times, and is of higher quality, especially because of advanced technology and greater resources. Several Dominicans also stated that in their country, unlike in the US, one may be denied admission to the emergency room if they don't have enough money to cover the services.

The sample was split evenly about whether they feel they are more likely, less likely, or just as likely to access emergency medical care here than in their home country. Those that felt they were more likely tended to value the higher perceived quality of care and those who'd access emergency medical care in the US less all cited the higher costs. When broken down by country of origin, the majority of the Dominican participants said they utilize emergency medical care more in the US, whereas the majority of the Guatemalan participants – who come from a country with largely free healthcare – said they utilize it less in the US.

DISCUSSION

While many participants appropriately described attempting to treat less severe health conditions at home, several people had high thresholds for visiting a doctor. None of them had insurance or primary care physicians, indicating these may be key barriers. Although this study did not assess undocumented status, most literature about Latin American immigrant utilization highlights that undocumented people – who are much more likely to be uninsured and lack primary care physicians – utilize EDs less than documented Americans.[9,22,23] However, for pediatric health emergencies, lacking a primary care physician is correlated with more ED visits since the ED can serve as a safety net substitute for primary care.[24] Given that many men avoided medical care in favor of healing at home, gender may also play a role. Machismo, a heightened masculinity commonly seen in Latin American cultures, has shown to prevent Latin American men from seeking mental health services; perhaps this phenomenon may extend to emergency care.[25] The most common source of healthcare information was from friends and family members, likely because shared language and life experiences increase trust and accessibility.[26] This highlights the importance of social networks for Latin American immigrants, who may know few people in the US upon arrival.

High poverty rates among Latin American immigrants impact their ability to purchase medical care.[2,27] Latin American families see low levels of employer-sponsored coverage because they more often work low-wage jobs, putting many Latin American immigrants in the Medicaid gap in which they make too much money to qualify for state insurance but not enough to purchase private insurance.[27] Because of this, community health centers are the predominant source of health care for 41% of Spanish-speaking Latin American immigrants, since these safety net clinics cater to low-income and underinsured patients.[2] This aligns with many participants' reliance on community health clinics or free clinics for medical care.

The long ED wait times mentioned by all participants can be attributed to nonurgent utilization of emergency rooms, which also increases cost of care and decreases quality of care for people with medical emergencies.[28] Lack of knowledge led to some participants visiting the ED for nonurgent situations like anxiety and tooth infections, but on the other side of the spectrum, some people refrained from accessing any medical care because they weren't aware of what services were available to them. Recently arrived immigrants are used to different health centers, prices, and cultural expectations of care, which is further compounded by the fact that nearly 80% of immigrants believe that using public programs that pay for health care can decrease one's chance for green card approval.[2,29]

Although most participants did not worry about being discriminated against in emergency rooms, several did. This represents a potential barrier to accessing emergency care since immigrants may worry about being mistreated – or even deported if they are undocumented – in emergency rooms, especially following spikes in anti-immigrant political rhetoric.[30] It also makes sense that for those that utilize emergency medical care more in the US, higher quality of care was the most common reason because that was the most cited positive factor of US emergency services across all participants. Parallel reasoning justifies high cost as the most common reason for using emergency medical care less in the US, since high cost appeared to be the biggest barrier in the sample.

There were several limitations to this study. Selection bias might have resulted from convenience sampling, although efforts were made to recruit participants during lunchtime and on weekends. Undocumented individuals are less likely to have participated due to the fear of deportation.[31,32] The results are not generalizable to the general population, especially since participants were recruited in one city. The resulting sample also included no one that identified as Indigenous and only two Afro-Latinx people, although cultural differences in race identification may have affected the way people reported their race.[33]

This study is explorative and identifies specific experiences that may be the basis for future research. There are studies that assess the impact of lacking a primary care physician on emergency department utilization, but a comprehensive quantitative study assessing this correlation among different subsects of immigrants (undocumented, pediatric, etc.) is warranted.[9,22-24] There is also no available research studying the impact of machismo on emergency medical care utilization, nor is there a comprehensive study addressing different Latin American immigrant perceptions of emergency medical care based on country of origin.

This study also highlighted several potential mechanisms for improving emergency medical care access and outcomes. The participants' reliance on free clinics, community health centers, or discounted payment plans highlights the importance of bolstering such services to increase medical care affordability. This would also connect immigrants with primary care services, thus reducing inappropriate usage of EDs.[34] Efforts to close the Medicaid gap and expand health insurance to those with minimum wage jobs would also make medical care easier to afford.[27] Efforts to increase the awareness of how the US healthcare system works are also crucial. Cost transparency in the ED, such as by having guidelines for estimated prices for specific services, would enable patients to make informed choices about the care they seek.[34] Health advocacy organizations can also employ immigrant social networks to spread information about how the healthcare system works, such as with pamphlets.[35]

The purpose of this study was to explore perceptions of and experiences with emergency medical services among Spanish-speaking Latin American immigrants. The responses provided by the participants highlight several strengths but also glaring pitfalls of accessing emergency medical care in the US. The results of this study inform many potential avenues of healthcare reform, bringing the US closer to increasing health equity for all residents.

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Ethical Approvals

This study was reviewed and exempted by the Brown University IRB.

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