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MAKING LANGUAGE ACCESS TO HEALTH CARE MEANINGFUL: THE NEED FOR A FEDERAL HEALTH CARE INTERPRETERS' STATUTE

ALVARO DECOLA*

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I. INTRODUCTION

In Miami, Florida, the misinterpretation of a word delays treatment for Willie Ramirez and results in the eighteen-year-old-year old living the rest of his life as a quadriplegic.¹ At a doctor's office in Merced, California, Ker Moua's son, acting as the communication conduit between the doctor and his non-English speaking mother, mistranslates the doctor's instructions with respect to the prescription medication, and she overdoses.² In Queens, New York, Moon Chul Sun, a Korean-speaking patient, is unable to communicate with doctors for three days until an interpreter that "spoke little Korean" tells him, while he is being discharged, that the only course of treatment was to take Tylenol.³ He dies a month later.⁴ And in

¹ See *Quadriplegic Gets Million-Dollar Settlement*, THE LAKELAND LEDGER, (Nov. 5, 1983), available at <http://news.google.com/newspapers?nid=1347&dat=19831105&id=vCUVAAAIAIBAJ&sjid=mvsDAAAIAIBAJ&pg=6967,1458958> (discussing the settlement Ramirez received after a medical malpractice suit, and how a Spanish word "intoxicado" was likely the cause of the delay in treatment that resulted in the life-long paralysis). See also Gail Price-Wise, *Language, Culture, And Medical Tragedy: The Case of Willie Ramirez*, HEALTH AFFAIRS, POLICY J. OF HEALTH SPHERE, (Nov. 19, 2008), <http://healthaffairs.org/blog/2008/11/19/language-culture-and-medical-tragedy-the-case-of-willie-ramirez/> (recounting the incident which includes interviewing family members).

² See *California Seeks to Stop the Use of Child Medical Interpreters*, N.Y. TIMES, (Oct. 30, 2005), available at <http://www.nytimes.com/2005/10/30/national/30interpreter.html> (reporting a common practice of using children as interpreters for their non-English speaking parents and its potential consequences). The inappropriate use of children as interpreters may compromise the quality of care given. Children do not have the medical vocabulary or maturity to understand and communicate medical issues accurately to their ill relative and other family members. They may be embarrassed or overwhelmed by having to ask sensitive questions or relay bad news.

³ See Audrey Daly, *How to Speak American: In Search of the Real Meaning of "Meaningful Access" to Government Services for Language Minorities*, 110 PENN ST. L. REV. 1005, 1006 (2006). See also Marc Santora, *Caught in the Health Care Maze: A Korean Family's Story*, N.Y. TIMES, (Jul. 26, 2004), available at <http://www.nytimes.com/2004/07/26/nyregion/caught-in-the-health-care-maze-a-korean-family-s-story.html?pagewanted=1>.

⁴ Santora, *supra* note 3.

Phoenix, Arizona, Griselda Zamora, a thirteen-year-old girl, dies from a ruptured appendix after being discharged from a local hospital, where she was given a pregnancy test and a diagnosis of gastritis.⁵

These cases illustrate a significant challenge facing a health care system that is unable to comply with federal regulations designed to address the needs of patients who are unable to communicate proficiently in English. One central tenet of the delivery of high-quality health care is the physician-patient relationship. Communication is essential to the development of this relationship and the status of patients' health is directly related to it.⁶ The communication gap between the increasingly language diverse population throughout the United States and their health care providers not only affects the health outcomes and lives of millions of limited English proficient (LEP) American taxpayers, but it also jeopardizes their legal rights.

Language proficiency can be a barrier to accessing health care services and understanding and exercising important rights, such as the right of self-determination to grant or withhold informed consent. It can also pose a barrier to complying with applicable responsibilities, and understanding other information provided by federally funded facilities. Title VI of the Civil Rights Act of 1964 provides that "[n]o person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."⁷ The Supreme Court has interpreted language to be a proxy for national origin and, as a result, discrimination on the basis of language is protected under Title VI.⁸ Furthermore, Executive Order 13166 requires all recipients of federal financial assistance to improve access to their LEP applicants and beneficiaries.⁹ In order to

⁵ See Amanda Scioscia, *Critical Connection, Language Isn't the Only Thing Lost in Translation as Hispanic Patients Struggle to Communicate with English-Speaking ER Doctors*, PHOENIX NEW TIMES NEWS, (Jun. 29, 2000), <http://www.phoenixnewtimes.com/2000-06-29/news/critical-connection/>. This article describes how after the Zamora's case, the hospital decided to employ staff-interpreters. The same practice is been implemented in hospitals throughout the area, because of the large number of limited English proficient patients needing these services.

⁶ See Moira A. Stewart, *Effective Physician-Patient Communication and Health Outcomes: A Review*, 9 CAN. MED. ASS'N J. 1423 (1995) (analyzing twenty-one studies focused on the doctor-patient relationship and concluding that the better the communication, the more likely the patient's health would improve).

⁷ 42 U.S.C.S. § 2000d (LEXIS 2010).

⁸ See *Lau v. Nichols*, 414 U.S. 563 (1974) (holding that the failure to provide adequate instruction for LEP children of Chinese descent constituted a violation of Title VI). The Court in *Lau* concluded that the San Francisco public school system must provide bilingual education to Chinese speaking students with limited English proficiency based exclusively on a Title VI analysis. See also Muneer I. Ahmad, *Interpreting Communities: Lawyering Across Language Difference*, 54 UCLA L. REV. 999, 1016 (2007).

⁹ See EXEC. ORDER NO. 13166, 65 Fed. Reg. 50121 (Aug. 11, 2000). The Order intended to achieve its purpose by mandating "each Federal agency ... [t]o examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency." *Id.*

improve access, recipients must implement meaningful language access to health services and programs. Current Title VI dispositions with respect to language are not strictly enforced, however, causing a hardship to those who face difficulty when seeking quality health care because of their lack of English proficiency.¹⁰

Currently, some health care facilities are trying to bridge the gap in communication by utilizing bilingual staff and technologically advanced systems where “patients connect with an interpreter via two-way video” or through the telephone.¹¹ Other facilities hire staff interpreters or contract with language agencies and telephone language lines, where an interpreter is on the phone while the doctor examines the LEP patient.¹² While these staff members and interpreters are merely proficient in the language, there is no formal testing, licensure, or certification that guarantees a minimum level of competency and quality to ensure that health care interpreters provide the “meaningful access” required by law.¹³

Language access barriers will not be overcome unless new statutory guidance is enacted that addresses both national standards for medical interpreters and translators, and procedures to strictly enforce current federal laws related to language access. Congress should enact a statute mandating the Department of Health and Human Services (DHHS) to establish a certification program for health care language interpreters, whereby health care facilities receiving federal funds and located in areas with a statistically significant LEP population are required to appoint or employ language interpreters who have met licensure/certification requirements guaranteed by an independent government body. The statute should be defined to create a procedural scheme where a LEP patient may enforce his or her rights under the statute in order to accomplish the intent of current language access laws.

Physicians and other health care providers usually have no way of confirming whether the interpreter, acting as the communication conduit with LEP patients, is accurate. Therefore, training and certification by an authority qualified to test these skills provides an objective verification of competence, ensuring that all participants involved in the medical examination of a LEP patient are communicating effectively.¹⁴ The failure to promote a policy whereby medical interpreters have to

¹⁰ See Siddharth Khanijou, *Disentangling Fact from Fiction: The Realities of Unequal Health Care Treatment*, 9 DE PAUL J. HEALTH CARE L. 855, 869 (2005).

¹¹ See, e.g., Newsletter Database, *Portable System Connects Patients to Interpreters; Strategic Notes*, HEALTH CARE STRATEGIC MGMT, Pg. 3(1) Vol.24 No.12, ISSN: 0742-1478, Dec. 1, 2006 (describing a new system where interpreters may be present from a remote location).

¹² See, e.g., Paula Heine, *Best Methods for Increasing Medical Translators for Limited English Proficient Patients: The Carrot or the Stick?* 18 J. L. & HEALTH 71, 73 (2004) (discussing the use of telephone language lines and costs associated with them). See also Scioscia, *supra* note 5 (reporting hospitals hiring staff interpreters to help bridge the gap in communication in an area where a great percentage of the population is LEP). In this particular area of Arizona, the interpreter’s office reported having provided services for 33,500 patients, during the first year of implementation of the program. *Id.*

¹³ See Exec. Order 13166, *supra* note 9.

¹⁴ Note: Physicians and medical personnel who are not proficient in the language of the patient have to rely on the accuracy of a language interpreter for communication. To determine interpreter accuracy, an independent verification – via certification, would provide the best tool to ensure accurate communication between LEP patients and physicians. “Health

meet minimum standards of qualifications not only jeopardizes the health outcomes of LEP patients, but also prevents patients from exercising their rights and increases the potential for malpractice liability of health care facilities. Exposure to civil actions based on “improper medical care, lack of informed consent, or breach of duty to warn” increases when physician-patient communication is flawed.¹⁵ Therefore, there are legal implications, public policy issues and financial incentives to promote the enactment of a statute that will help bridge the communication gap between health care facilities and LEP patients. Moreover, a federal health care interpreter statute would ensure compliance with the existing federal laws and provide the meaningful access intended by Congress when creating them.

This Note will argue that there are strong public policy, and legal and equity considerations for Congress to enact a federal statute to address the inadequacies of the current policies and regulations pertaining to language access to health care. The issue has become a significant one throughout the United States, given the influx of LEP Americans navigating the health care system. Part II of this writing discusses the existing federal laws dealing with language access and the hurdles faced by LEP individuals in bringing legal action, because of existing case law on the subject. Part II also describes other federal statutes considering language access and how the same rationales can be applied to a statute for the provision of certified interpreters in the health care context. Part III of this Note argues that there is a lack of minimum standards of competency required from language providers that makes the quality of language services inconsistent, and often deficient, throughout the nation. Consequently, the health outcomes of LEP patients are jeopardized and the exposure to civil liability on the part of physicians and health providers is increased. Part III also argues that current practices with respect to policy, legal, and financial considerations justify the enactment of a federal statute dealing with the certification of health care interpreters. The Note provides some policy issues that may be considered in the enactment of a statute. Part IV concludes that the enactment of a federal health care interpreter statute will ensure meaningful access to health care for LEP patients and will help health care providers comply with the intent of current laws.

II. BACKGROUND

Since the 1940s, immigration has been the major contributor to population and economic growth in the United States.¹⁶ From 1980 to 2000, the total population of the United States grew about twenty-five percent while the number of Americans who spoke a language other than English in their homes grew by almost one hundred

care administrators, for example, would like to be able to count on a credible external system to guarantee the quality of their interpreters, just as they are able to depend on external certification/licensure programs to assure the capacity of other professionals.” Cynthia E. Roat, *Certification of Health Care Interpreters in the United States; A Primer, a Status Report and Considerations for National Certification*, CA. ENDOWMENT, 1 (2006).

¹⁵ See Khanijou, *supra* note 10, at 869-70 (describing the potential malpractice civil penalties for failing to provide language services to bridge the communication gap between patients and doctors).

¹⁶ See Kefa M. Otiso & Bruce W. Smith, *Immigration and Economic Restructuring in Ohio's Cities*, 105 OHIO J. SCI. 133 (2005) (discussing immigration trends in the United States in general and Ohio in particular).

percent.¹⁷ By 2005, close to 23 million people reported speaking English less than “very well.”¹⁸ As a natural consequence, hospitals and health facilities throughout the United States have experienced an influx of LEP patients. Some studies reveal that eighty percent of hospitals encounter LEP patients “at least monthly, if not weekly or daily,” while forty-three percent of hospitals are reported to have daily encounters with LEP patients.¹⁹ These figures reveal that every day, thousands of LEP patients visit health care facilities throughout the country in search of medical care.

For a large number of these patients, explaining medical issues becomes an insurmountable task because of the challenge of communicating effectively with the providers.²⁰ Often, this gap in communication leads to medical complications and untreated ailments.²¹ Furthermore, the legal rights and recourses that every patient enjoys may be jeopardized or trumped by virtue of the lack of language proficiency, with consequences unlikely to occur to the English-speaking patient. While the issue may not be apparent in routine patient checkups, it becomes evident when a LEP patient is required to engage in activities requiring a more in-depth understanding of the language, such as executing an informed consent form, undergoing a particular line of treatment, or creating a living will that specifies whether to receive or reject life-sustaining medical care in the event of a life-threatening injury, illness, or incapacitation.²² Good verbal communication between doctors and patients is

¹⁷ Daly, *supra* note 3, at 1009-10. These figures reflect that English language proficiency is not directly related to citizenship or legal permanent residency status. Many naturalized citizens and permanent residents possess basic English proficiency to function in society. But these same individuals are not able to comprehend and meaningfully participate in important decision-making processes when more sophisticated terminology and vocabulary, often associated with medical care, is involved.

¹⁸ *Selected Social Characteristics in the United States*, U.S. CENSUS BUREAU, (2005), http://factfinder.census.gov/servlet/ADPTable?_bm=y&q_r_name=ACS_2008_3YR_G00_DP3_YR5&-geo_id=010000US&-ds_name=&-_lang=en&-redoLog=false.

¹⁹ *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*, HEALTH RESEARCH & EDUCATIONAL TRUST, (2006), <http://www.medbridge.net/industry/languageservices.pdf>. The survey reflected that “large and teaching hospitals and those in urban settings were more likely to see a higher number of patients with LEP.” *Id.*

²⁰ See Christian Basi, *Health Information Not Communicated Well to Minority Populations*, *MU Researcher Finds*, NEWS BUREAU U. OF MO., (Oct. 29, 2009), <http://munews.missouri.edu/news-releases/2009/1029-health-information-not-communicated-well-to-minority-populations-mu-researcher-finds/> (reporting the findings of a study showing that “[i]n the LEP population, researchers found, in addition to health literacy issues, those with limited English proficiency had a significantly reduced access to healthcare”). LEP patients, as a result, “make fewer doctor visits . . . receive less screenings and preventative care[, and] also may delay going to the doctor to avoid dealing with the frustrations of language problems.” *Id.*

²¹ See, e.g., *Quadriplegic Gets Million-Dollar Settlement*, *supra* note 1; *California Seeks to Stop the Use of Child Medical Interpreters*, *supra* note 2; Daly, *supra* note 3; Scioscia, *supra* note 5.

²² See Bruno G. Romero, *Essays From the Honorable James J. Gilvary Symposium on Law, Religion & Social Justice: “Justice for Strangers? Legal Assistance and the Foreign Born”*: *Here are Your Right Hands: Exploring Interpreter Qualifications*. 34 U. DAYTON L.

essential in formulating a valid diagnosis and a successful treatment plan and in allowing patients to exercise their rights and autonomy.

A. Existing Federal Law

1. Title VI

Title VI of the Civil Rights Act of 1964 provides the legal foundation for language access. In order to enforce the Title VI prohibitions of discrimination on the basis of national origin, race, color, or gender, the federal government through the DHHS has issued “rules, regulations, or orders of general applicability” on every health care facility receiving federal funding.²³ Recipients include state and local governments and any agency or private organization receiving any federal funding, whether directly or indirectly.²⁴ Federal funding may be in the form of grants, subsidies, training, use of equipment, donations and other assistance, and the coverage extends to all recipients’ programs and activities.²⁵

2. Executive Order 13166

Executive Order 13166, enacted in August 2000 by President Bill Clinton, requires federal funding recipients to provide “meaningful access” to the services and programs offered to the general population.²⁶ The Executive Order “was intended to compel compliance with Title VI provisions that proscribe policies and practices that have a disparate impact based on national origin.”²⁷ Following the Order, the DHHS, through the Office for Civil Rights (OCR), issued a Policy Guidance to assist federal funding recipients, including health care providers, in ensuring meaningful access by strongly encouraging the use of language interpreters

REV. 15, 16 (2008) (discussing common misconceptions about proficiency in a foreign language). Individuals who may possess enough English proficiency to undergo a routine medical evaluation do not necessarily possess the proficiency to understand the legal implications of an informed consent form or other more in-depth medical procedures.

²³ See 42 U.S.C.S. 2000d.

²⁴ See Equal Employment Opportunity Program, *Title VI, Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, NAT’L ARCHIVES AND RECORDS ADMIN., <http://www.archives.gov/eo/laws/title-vi.html> (last visited Jan. 22, 2010). All federal funding recipients are subject to the rules and regulations under Title VI, including those “recipients [that] operate in jurisdictions in which English has been declared the official language. Nonetheless, these recipients continue to be subject to federal non-discrimination requirements, including those applicable to the provision of federally assisted services to persons with limited English proficiency.” *Id.*

²⁵ *Id.*

²⁶ EXEC. ORDER NO. 13166 (Aug. 11, 2000).

²⁷ Daly, *supra* note 3, at 1008 (explaining how most federal departments and agencies have enacted disparate impact regulations and, although they may contain slight textual differences, they all operate to prohibit the use of “criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin”).

in health care and the translation of forms to overcome the language barrier.²⁸ In August 2003, President George W. Bush upheld the Executive Order and issued a revised guidance policy.²⁹

3. Extent of Language Assistance Obligations

President Bush's Executive Order provides that federal funding recipients must take reasonable steps to ensure meaningful access to programs and services and provides four factors to be considered in determining the extent and obligation to provide language services.³⁰ First, the number or proportion of LEP individuals served or eligible to be served within the service population should be considered.³¹ Second, the frequency of contact between the LEP population and the programs and services offered by the recipient of federal funds must be taken into account.³² The third factor, and essentially the one that distinguishes health care services from other services [and the holding in *Sandoval*],³³ is the nature and importance of the program or service.³⁴ Lastly, providers should consider the resources available to recipients, and the costs.³⁵

Based on these factors, it follows that all federal funding recipients are liable if they fail to provide meaningful language access to their services and programs. Moreover, according to the third factor, health care providers arguably carry a higher obligation to ensure language access, given the "nature and importance" of the services they provide.³⁶ While costs may be the factor cited most often by health care facilities, especially large hospitals and clinics, the OCR Policy Guidance specifically states that "[l]arge entities and those entities serving a significant number or proportion of LEP persons should ensure that their resource limitations are well-substantiated before using this factor as a reason to limit language assistance."³⁷

4. Enforcement of Federal Regulations

The OCR for each federal department or agency³⁸ ("federal agency") is responsible for maintaining compliance and ensuring that its programs are non-

²⁸ Policy Guidance Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52762, 52763, (Aug. 30, 2000) (defining LEP individuals as falling within the national origin minority classification).

²⁹ 68 Fed. Reg. 47311 (Aug. 8, 2003).

³⁰ *Id.* at 47313-14.

³¹ *Id.* at 47314.

³² *Id.*

³³ *See Alexander v. Sandoval*, 532 U.S. 275 (2001).

³⁴ 68 Fed. Reg. 47311 (Aug. 8, 2003).

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.* at 47315.

³⁸ Index of federal Departments and Agencies, http://www.usa.gov/Agencies/Federal/All_Agencies/index.shtml (last visited Oct. 22, 2010).

discriminatory.³⁹ Procedurally, a complaint must be filed with the federal agency dispensing federal funds within 180 days of the alleged violation, and the LEP claimant “must identify the specific regulations violated by the act.”⁴⁰ Once reported, the OCR is required to investigate the alleged incident to assess whether it constitutes discrimination and take disciplinary action if needed.⁴¹ The OCR has the authority, after investigating and finding violations, to terminate federal funding for non-compliance.⁴² For example, the withholding of federal funding, coupled with the OCR complaints filed on behalf of LEP patients, were the trigger to enhanced language services at “Boston City Hospital (now Boston Medical Center) in Massachusetts, Harborview Medical Center in Washington State, and San Francisco General Hospital in California.”⁴³

In fact, “OCR complaints have arguably been responsible for the inception and growth of many of the premier hospital-based interpreter services programs in the USA.”⁴⁴ However, scholars and organizations dedicated to protect minority groups opine that “regulations” pertaining to language issues are unlikely to be enforced due to the “inadequate funding and a shortage of administrative resources” that “has reduced administrative enforcement to all but a dead letter.”⁴⁵ Despite the action taken by some entities to improve language access, the issue remains largely unresolved and the need for qualified interpreters continues to grow beyond the traditional metropolitan areas.⁴⁶

³⁹ Khanijou, *supra* note 10, at 864.

⁴⁰ *Id.* (outlining the complaint process under Title VI).

⁴¹ *Id.* at 864-65.

⁴² See *How OCR Enforces Civil Rights Discrimination Laws and Regulations*, U.S. DEP’T. OF HEALTH AND HUMAN SERVS., <http://www.hhs.gov/ocr/civilrights/activities/process/index.html> (last visited Mar. 15, 2010).

⁴³ See Alice Hm Chen, et al., *The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond*, 22 (Suppl 2): 362, 363-67, J. GEN. INTERNAL MED. (2007), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150609/> (last visited Jan. 22, 2010).

⁴⁴ *Id.* This article argues that the threat of withholding federal funds caused major health care facilities to implement language access measures that resulted in the development of language service programs such as having language interpreters on staff for hospitals located in major metropolitan areas where contact with LEP patients is a daily occurrence.

⁴⁵ See Khanijou, *supra* note 10, at 865. See also *Language Access in Health Care Settings*, NATIONAL COUNCIL OF LA RAZA, <http://www.nclr.org/content/policy/detail/1771/> (last visited Feb. 08, 2010) (arguing that “[c]urrent language access regulations are not enforced, causing a barrier to those seeking quality health care”). The National Council of La Raza (NCLR) is a national Latino civil rights and advocacy organization. It also discusses the issue of children functioning as interpreters and states that “[t]he pervasive lack of translated materials and interpreter services at health facilities, despite legal obligations requiring language access at health entities receiving federal funding often forces children to serve as interpreters for their families, and places them in inappropriate settings.” *Id.*

⁴⁶ Heine, *supra* note 12 (arguing how the need for competent language access is starting to affect rural areas). In addition, it elaborates on how physicians and health care facilities not located in large cities confront the issue of language providers’ lack of competency and struggle to obtain reimbursement for language services. *Id.*

B. Case Law Dealing With Issue of Language Access

1. Court Imposed Limitations to Actions under Title VI

By enacting Title VI, Congress intended to end intentional discrimination against minorities, such as the segregation of black patients to different wards of hospitals to be treated by black doctors.⁴⁷ Another goal of Title VI was to end practices that had a discriminatory effect, such as the failure to provide additional educational services to students who were LEP.⁴⁸ While the issue of language under Title VI has not seen a broad amount of litigation, court rulings with respect to this issue have been less than consistent.⁴⁹

In *Alexander v. Sandoval*,⁵⁰ a very controversial case dealing with this issue, the Supreme Court obliterated any impetus behind private parties seeking relief for language access under Title VI.⁵¹ In this case, *Sandoval* claimed that the Alabama Department of Public Safety policy, by ONLY administering driver's license tests in English after the state declared English as its official language, was discriminating against non-English speakers on the basis of their national origin.⁵² The plaintiffs argued that the new English-only policy had a disparate impact on LEP individuals with different national origins because they would be prevented from obtaining a driver's license.⁵³ The *Sandoval* Court held that while private parties could bring actions where agency recipients of federal funds acted with discriminatory intent,⁵⁴ they could not bring actions under Title VI for discrimination based on disparate

⁴⁷ *Id.* at 76. See also Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination – It Shouldn't Be So Easy*, 58 *FORDHAM L. REV.* 939 (1990) (addressing the relative ease in which defendants prevailed at trials against plaintiffs claiming that policies had a negative racial impact).

⁴⁸ See *DHEW Memo Regarding Language Minority Children*, U.S. DEPT. OF EDUCATION, (May 25, 1970), <http://www2.ed.gov/about/offices/list/ocr/docs/lau1970.html>.

⁴⁹ Ahmad, *supra* note 8, at 1086 (contrasting *Lau*, 414 U.S. at 563, to *Franklin v. District of Columbia*, 960 F. Supp. 394 (D.D.C. 1997) (holding that the disqualification of Hispanic inmates from certain prison programs was due to their limited English proficiency and not based on race, or national origin, and therefore dismissing the Title VI claim), *rev'd* on other grounds, 1563 F.3d 625 (D.C. Cir. 1998)).

⁵⁰ *Alexander v. Sandoval*, 532 U.S. 275 (2001). The decision in this case was a 5-4 split. The Court deprived private parties from asserting Title VI actions unless plaintiffs could prove intentional discrimination on the part of recipients of federal funding, with respect to the administration of their services and programs.

⁵¹ See Khanijou, *supra* note 10, at 863 (describing the decision in this case to be considered a controversial one in

the litigation of Title VI issues). Some organizations also consider the *Sandoval* decision to be "highly controversial as it essentially re-writes over 30 years of judicial opinions on Title VI disparate impact cases." Environmental Justice Resource Center, U.S Environmental Racism at the World Conference Against Racism, *available at*: <http://www.ejrc.cau.edu/nbejndurban.htm> (last visited Oct. 22, 2010).

⁵² *Sandoval*, 532 U.S. at 278-79.

⁵³ *Id.*

⁵⁴ *Id.* at 279-80.

impact alone.⁵⁵ Four Supreme Court Justices dissented, reasoning that Congress intended to include a private enforcement right to disparate impact cases brought under Title VI and citing previous Court decisions.⁵⁶

The issue of language access in health care may be distinguishable from *Sandoval* because of the nature and importance of services sought and different regulations applicable to health care providers.⁵⁷ Although some scholars argue that LEP individuals “should challenge their exclusion from meaningful access to medical services on equal protection grounds as purposeful discrimination,”⁵⁸ the holding in *Sandoval* presents the biggest hurdle for an action based on language access under Title VI.

C. Other Federal Statutory Language Access Provisions

1. Federal Statutes

The legislature has dealt with the issue of language access in other areas of the law where language access is construed as essential to fully exercise rights and privileges granted to all Americans. Recognizing the importance of the issue, Congress has enacted various statutes addressing language access for LEP individuals.⁵⁹ Most relevant are The Food Stamp Act of 1964, which considers the issue and provides for the translation of documents and use of bilingual personnel;⁶⁰

⁵⁵ *Id.* at 293.

⁵⁶ *Id.* at 297 (discussing how five years after reviewing the same issue,

[they] more explicitly considered whether a private right of action exists to enforce the guarantees of Title VI and its gender-based twin, Title IX. See *Cannon v. University of Chicago*, 441 U.S. 677, 60 L. Ed. 2d 560, 99 S. Ct. 1946 (1979). In that case, [they] examined the text of the statutes, analyzed the purpose of the laws, and canvassed the relevant legislative history. [Their] conclusion was unequivocal: “We have no doubt that Congress intended to create Title IX remedies comparable to those available under Title VI and that it understood Title VI as authorizing an implied private cause of action for victims of the prohibited discrimination.” *Id.*, at 703).

⁵⁷ 65 Fed. Reg 52762, 52765 (Aug. 11, 2000). See also NAT’L ARCHIVES AND RECORDS ADMIN., *supra* note 24 (indicating that while many commentators have interpreted the *Sandoval* holding as “impliedly striking down the regulations promulgated under Title VI . . . and Executive Order 13165, . . . the Department of Justice has taken the position that it is not the case”).

⁵⁸ Barbara Plantiko, *Not-So-Equal Protection: Securing Individuals of Limited English Proficiency with Meaningful Access to Medical Services*, 32 GOLDEN GATE U.L. REV. 239, 262 (2002) (arguing that despite the holding in *Sandoval*, LEP patients who have been denied meaningful access to medical services may have a claim for violation of the Equal Protection Clause, analogizing the failure to provide language interpreters to LEP patients to “the provision of interpreters under the Americans with Disabilities Act where courts have been extremely reluctant to excuse a health care provider’s failure to provide sign language interpreters under an “undue burden” defense”).

⁵⁹ See, e.g., Voting Rights Act of 1965, 42 U.S.C.S. § 1971 (LEXIS 2009); 42 U.S.C.S. § 1973aa-1a(b) (LEXIS 2009); Food Stamp Act of 1964, 7 U.S.C.S. § 2020 (LEXIS 2009); Court Interpreters Act of 1978 28 U.S.C.S. § 1827 (LEXIS 2009).

⁶⁰ 7 U.S.C.S. § 2020(e)(1)(B). In pertinent part, the Act requires the state agencies in charge of the administration of the Act to “comply with regulations of the Secretary requiring

The Voting Rights Act of 1965, which requires bilingual voting materials in areas where there is a substantial LEP population in order to provide access to the political process;⁶¹ and lastly, and most pertinent, The Court Interpreters Act of 1978, enacted to ensure due process to LEP criminal defendants.⁶² The Court Interpreters Act can provide the administrative framework for a statute pertaining to health care interpreters.

III. ARGUMENT

A. *The Need for a Statute*

Congress has taken affirmative steps to ensure access to language minorities in past legislation.⁶³ Whether by including specific provisions for LEP individuals, as in The Food Stamp Act and The Voting Rights Act, or by enacting a statute to ensure competent language access to the courts, Congress recognizes the need to vest its linguistically diverse population with the rights and responsibilities afforded to all American citizens.⁶⁴ Regardless of whether health care is considered a right or a privilege, access to health care, from a public policy perspective, guarantees the welfare of the greatest number of people, which enables people to participate in the political, social, and economic life and advancement of their society. In a country with a multi-cultural, diverse population like the United States, ensuring access to health care, by extension, includes access for language minorities. Although federal

the use of appropriate bilingual personnel and printed material in the administration of the program in those portions of political subdivisions in the State in which a substantial number of members of low-income households speak a language other than English.” *Id.*

⁶¹ 42 U.S.C.S § 1973aa-1a(b). The Act requires the provision of bilingual materials in areas where census based data shows that:

more than 5 percent of the citizens of voting age of such State or political subdivision are members of a single language minority and are limited-English proficient; more than 10,000 of the citizens of voting age of such political subdivision are members of a single language minority and are limited-English proficient; or in the case of a political subdivision that contains all or any part of an Indian reservation, more than 5 percent of the American Indian or Alaska Native citizens of voting age within the Indian reservation are members of a single language minority and are limited-English proficient.

Id. at (b)(2)(A)(i)(I)-(III).

⁶² 28 U.S.C.S. § 1827. This Act became the framework for the creation and implementation of state court interpreter certification programs. The National Center for State Courts lists forty states that have implemented, or will in the near future, certification programs to ensure equal access to the courts. See *Consortium for Language Access in the Courts, Which states belong to the Consortium*, NAT’L CENTER FOR STATE COURTS, http://www.ncsconline.org/D_Research/CourtInterp/CICourtConsort.html (last visited Feb. 5, 2010).

⁶³ See 42 U.S.C.S. § 1971, 42 U.S.C.S. § 1973aa-1a(b); 7 U.S.C.S. § 2020; 28 U.S.C.S. § 1827.

⁶⁴ See 42 U.S.C.S. § 1971, 42 U.S.C.S. § 1973aa-1a(b); 7 U.S.C.S. § 2020; 28 U.S.C.S. § 1827.

regulations have attempted to ensure it, meaningful language access remains an unresolved issue.⁶⁵

Congress should enact a statute directing the DHHS to establish a certification program for health care language interpreters, whereby health care facilities receiving federal funds and located within areas with a statistical substantial LEP population are to appoint or employ language providers who have met minimum standards of competency guaranteed by an independent government body. The statute should be defined to create a procedural scheme where a LEP patient may enforce his or her rights under such statute. The statute should use the framework of the Court Interpreters Act, where a federal Department, in this case DHHS, is charged with establishing a program for identifying “‘certified’ and ‘otherwise qualified’ interpreters.”⁶⁶

1. The Court Interpreters Act

Congress confronted the issue of language access directly and forcibly during the 1970s. The criminal justice system and the courts were faced with the issue of access to LEP defendants. For example, in the federal courts, “[t]he courts’ failure to appoint qualified interpreters became a major concern.”⁶⁷ Eight years after the court held that a LEP defendant was deprived of exercising certain constitutional rights because of the failure to appoint a qualified interpreter to assist during trial,⁶⁸ Congress enacted the Court Interpreters Act of 1978.⁶⁹ The Act provides for the appointment of the “most available certified interpreter” to provide interpretation services to LEP parties and witnesses during any court proceeding initiated by the United States.⁷⁰ The Act did not create new constitutional rights for defendants⁷¹ and did not expand existing constitutional safeguards. Rather, it was enacted “to mandate

⁶⁵ See *Language Access in Health Care Settings*, *supra* note 45 (stating that despite current federal laws and regulations providing for language access to LEP patients, the lack of compliance makes the issue still unresolved).

⁶⁶ See 28 U.S.C.S. 1827(a).

⁶⁷ See Mollie M. Pawlosky, *When Justice is Lost in the “Translation”*: *Gonzalez v. United States*, an “Interpretation” of the Court Interpreters Act of 1978, 45 DEPAUL L. REV. 435, 443 (1996) (discussing the legislative history of the Act and the consistent appointment of unqualified interpreters). See also, 123 Cong. Rec. S37, 215 (1977) (providing excerpt of Senate Judiciary Report No. 95-569).

⁶⁸ *United States v. Negron*, 434 F.2d 386 (2d Cir.1970). *Negron* is a seminal case on the issue of court interpreters. In *Negron*, a Puerto Rican criminal defendant, unable to communicate or participate in his defense without the assistance of an interpreter, was convicted of murder. On appeal, the Court held that the defendant’s Sixth Amendment’s guarantee of a right to be confronted with adverse witness was denied by not providing a language interpreter. *Id.* Further, the court stated that “[c]onsiderations of fairness ... forbid that the state should prosecute a defendant who is not present at his own trial.” *Id.* at 389.

⁶⁹ See Pawlosky, *supra* note 67.

⁷⁰ 28 U.S.C.S. § 1827.

⁷¹ While the United States Constitution does not provide specific language to afford a criminal defendant the right to an interpreter, courts have derived such right from the exercise of other constitutional rights. It is noteworthy that the only state constitution that provides for the right to an interpreter is California. See CAL. CONST. art. 1 § 14.

the appointment of interpreters under certain conditions and to establish statutory guidance for the use of [interpreters] . . . to ensure that the quality of the translation [did] not fall below a constitutionally permissible threshold.”⁷²

While the constitutional and legal rights of a patient differ from those of a criminal defendant, the rationale behind utilizing a certified interpreter for LEP criminal defendants logically extends to LEP patients.⁷³ “Use of certified interpreters ensures that the criminal defendant [patient] who is not fluent in English is given an accurate account of the proceedings [medical procedure], and that the other . . . participants understand exactly what the non-English speaking individual is saying.”⁷⁴ The enactment of a health care interpreter statute may not provide an instant cure to the issue of language access in health care, just as the Court Interpreters Act did not,⁷⁵ but it would be a step in the right direction and would urge health care providers to effectuate compliance with existing regulations and assure competency and consistency in the provision of services to LEP patients.⁷⁶

2. Quality of Current Language Services in the Health Care Industry

In an effort to comply with DHHS regulations, some health care facilities have been attempting to overcome the language barrier by utilizing bilingual staff members and volunteers and creating language banks.⁷⁷ Others are resorting to language agencies and in-house interpretation services.⁷⁸ Nevertheless, these attempts fail to fully comply with the spirit of the regulations because even when the services of “official interpreters” were utilized, significant errors were revealed that

⁷² *United States v. Joshi*, 896 F.2d 1303, 1309 (11th Cir. 1990). In *Joshi*, the court recognizes the right of a LEP defendant to receive simultaneous interpretation during trial and the importance of the quality of the translation; however, it narrowly defines the inquiry as to whether the translation “made the trial fundamentally unfair.” *Id.* (citing *Valladares v. United States*, 871 F.2d 1564, 1566 (11th Cir. 1989)).

⁷³ Note that the legal rights of a criminal defendant and a patient are fundamentally different, but the rationale behind the right to an interpreter is to fully participate in the exercise of such fundamental rights.

⁷⁴ *United States v. Bailon-Santana*, 429 F.3d 1258, 1260 (9th Cir. 2005).

⁷⁵ The certification of court interpreters pursuant to the Court Interpreters Act did not abruptly change the landscape of language access in the federal courts but it did provide a framework for states to start implementing analogous interpreter programs and statutes. See *Report of the Third Circuit Task Force on Equal Treatment in the Courts*, COMMISSION ON GENDER, COMMISSION ON RACE & ETHNICITY, 42 VILL. L. REV. 1355, 1726 (1997). See also ARK. CODE ANN. § 16-64-111 (LexisNexis 2009); WASH. REV. CODE ANN. § 2.43.010 (LexisNexis 2008); KY. REV. STAT. ANN. § 30A.410 (LexisNexis 2009).

⁷⁶ A health care interpreter statute would compel providers to comply with existing laws and regulations. See EXEC. ORDER 13166 (Aug. 11, 2000) and 65 Fed. Reg. 50121.

⁷⁷ See, e.g., Murray Schumach, N.Y. TIMES, Mar. 26, 1977, at 28 (discussing the use of volunteers to act as translators).

⁷⁸ See *A Language Bank Aids Elmhurst Hospital, Language Access*, CA. ENDOWMENT, http://www.calendow.org/Collection_Publications.aspx?coll_id=22&ItemID=312 (last visited Mar. 15, 2010) (discussing how hospitals are resorting to bilingual staff and language agencies to bridge the language gap).

“were judged to have the potential to cause clinical problems.”⁷⁹ Despite these attempts to provide meaningful language access and bridge the communication gap between an increasing number of LEP patients and health care providers, “[c]ommunication problems between doctors and patients who speak different languages occur nationwide.”⁸⁰

The main issue affecting communication resides in the quality of the interpretation.⁸¹ One factor contributing to this dilemma is the common misconception that any individual who is bilingual may competently act as an interpreter.⁸² This misconception occurs across the board, but it becomes detrimental in areas where life, freedom, or property is at stake, as is often the case in the health care and criminal justice systems. In some state court systems, court interpreter statutes are not strictly enforced; interpreters are appointed under the assumption that bilingualism is sufficient to qualify an individual as a court interpreter.⁸³ Similarly, hospitals and health care facilities utilizing the services of untrained bilingual individuals place an undue burden on LEP patients.⁸⁴ Even when these facilities utilize interpreters that have undergone some training, there is no way to ensure that the interpreter is proficient enough to perform the translation because there are no national standards for medical interpreters, unlike interpreters for the hearing impaired or court interpreters.⁸⁵

⁷⁹ See Erin N. Marcus, M.D., *When a Patient Is Lost in the Translation*, N.Y. TIMES, Apr. 8, 2003, § F, at 7 (describing a study from the Medical College of Wisconsin and Boston University examining the transcripts of 13 audio-taped visits of Spanish speaking patients at a pediatrics clinic). In this particular study, “[s]ix encounters involved an official hospital interpreter; seven involved an ‘ad hoc’ interpreter like a nurse, social worker, or, in one case, an 11-year-old sibling.” *Id.* After studying the errors committed by the different interpreters, it was found that “[a]lthough the hospital interpreters’ errors were significantly less likely to cause problems than those of the ad hoc interpreters... ‘these findings support the conclusion that most hospital interpreters do not receive adequate training.’” *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² See Romero, *supra* note 22 (discussing common misconceptions and bilingualism).

⁸³ See Alice J. Baker, *A Model Statute to Provide Foreign-Language Interpreters in the Ohio Courts*, 30 U. TOL. L. REV. 593 (1999). See also Romero, *supra* note 22 (exploring the levels of bilingualism and common misconceptions about proficiency in a foreign language).

⁸⁴ See *Language Services Action Kit*, NAT’L HEALTH LAW PROGRAM, 43, http://www.cmf.org/usr_doc/LEP_actionkit_reprint_0204.pdf (last visited Feb. 5, 2010) (addressing the fact that LEP “patients may suffer direct consequences because they do not fully understand a diagnosis or treatment” and that “[u]ntrained interpreters are prone to omissions, additions, substitutions, and volunteered answers”).

⁸⁵ See Roat, *supra* note 14, at 7. See also, *Registry of Interpreters for the Deaf Certification Descriptors*, NAT’L CREDENTIAL DESCRIPTORS FOR SIGN LANGUAGE INTERPRETERS, http://www.deafinl.com/PDF/National_Credential_Descriptors.pdf (last visited Jan. 23, 2010) (describing the different levels of certification and the skills and standards required to fulfill these levels). See also, *Federal Court Interpreter Program*, U.S. COURTS, http://www.uscourts.gov/interpretprog/interp_prog.html (last visited Jan. 23, 2010) (outlining the different levels of certification and the standards of practice for court interpreters).

Another factor is that doctors and medical staff at health care facilities are not trained to assess language competence and may confuse levels of proficiency, like “survival English.”⁸⁶ An interpreter must understand sophisticated medical and legal terminology in order to understand a medical diagnosis, a course of treatment, or the patient’s rights when executing documents such as confidentiality notices and informed consent forms. A third factor is the cost associated with providing medical interpretation.⁸⁷ In order to ensure quality of language services and, in turn, provide meaningful access to health care, it is paramount to address the issue of qualifications and competency of medical interpreters.

3. Certification of Medical Interpreters

Medical interpretation has been practiced for many years.⁸⁸ According to the Bureau of Labor Statistics, in 2008 more than six thousand medical interpreters were working in the health care field.⁸⁹ It is projected that employment for interpreters will “increase 22% over the 2008-18 decade.”⁹⁰ At the present time, however, there are no national standards governing certification or licensure for health care interpreters.⁹¹ While performing duties that may have detrimental consequences to the health of patients if ill-performed, health care interpreters are not required to meet a minimum standard of competency to guarantee the quality of their work.⁹² Most other professionals in the health care field, including physicians, nurses, pharmacists, and sonographers, among others, depend on external certification or licensure programs to assure their capacity.⁹³

⁸⁶ Baker, *supra* note 83, at 602 (explaining that those who are not trained to assess language competence have difficulty in distinguishing between non-English speakers, who possess only minimum language skills and those with more sophisticated skills).

⁸⁷ See Mona T. Peterson, *The Unauthorized Protection of Language Under Title VI*, 85 MINN. L. REV. 1437, 1439 (2001).

⁸⁸ See, e.g., *Historical Timeline: 1969-2003, LANGUAGE ACCESS SERVS IN HEALTH CARE IN SEATTLE, WA.*, http://docs.google.com/viewer?a=v&q=cache:XfqLUwuQr5cJ:https://depts.washington.edu/ethnomed/InterpretHistorySeattle.pdf+1990+hospitals+employing+interpreters&hl=en&gl=us&pid=bl&srcid=ADGEEsj1GR8CKG5WdxwKP_tBQb2ceSSgqDfjILNR1QV5j13gJ7wXSj2t_WbAv1ynsrBJRQ (last visited Mar. 15, 2010) (presenting the history of this field of work in the State of Washington).

⁸⁹ Bureau of Labor Statistics, *Occupational Outlook Handbook, 2010-11 Edition, Interpreters and Translators*, U.S. DEP’T OF LABOR, <http://www.bls.gov/oco/ocos175.htm> (last visited Feb. 4, 2010) (providing an overview of the nature of these fields of work, the training and qualifications required, the possibilities for advancement and employment and projections for employment).

⁹⁰ *Id.*

⁹¹ See Peterson, *supra* note 87, at 1439. See also Chen, *supra* note 43.

⁹² Roat, *supra* note 14 (describing how many groups, including health care administrators, have a particular interest in the creation of interpreter certification). The article also indicates that the main reasons for not having a certification are “cost, the nature of certification and the current stage of development of spoken language health care interpreting as a field.” *Id.* It is noteworthy that this report was published in 2006 as the writer believes the issue of certification for health care interpreters is ripe as of 2010.

⁹³ *Id.*

4. State Initiatives

Since there are no federal standards for certification of health care interpreters,⁹⁴ and there is a void with respect to statutory guidance in this area, most states, even those that have established a Medicaid reimbursement scheme for language services, have not addressed the issue of certification.⁹⁵ Although certification is not required to be reimbursed for services, it is indisputable that “addressing the qualifications and competency of medical interpreters and translators – whether through the establishment of training, assessment, and/or certification standards – is essential to ensuring the quality of services provided.”⁹⁶ With the increased need for language services⁹⁷ and the lack of federal guidance, a handful of states have taken the initiative to address the issue of interpreter competence. Some already have certification programs, while others are exploring the possibilities.⁹⁸

The National Council on Interpreting in Health Care (NCIHC) has played a significant role for states and health care facilities in the move for standardized expectations and raising the quality of health care interpreting.⁹⁹ In 2004, the NCIHC published the National Code of Ethics for Interpreters in Health Care, and in 2005, they published National Standards of Practice for Interpreters in Health Care.¹⁰⁰ While some states and health care providers have benefited from the guidance provided by the Council, issues related to the consistent application of these standards make federal statutory guidance imperative.

⁹⁴ *Id.* (stating that, at the present, there is no national standards for the certification of health care interpreters).

⁹⁵ Note that only a few states have statutorily addressed the issue of certification of health care interpreters. *Id.*

⁹⁶ Chen, *supra* note 43.

⁹⁷ See Bureau of Labor Statistics, *supra* note 89 (projecting an increase in the need for health care interpreters).

⁹⁸ See, e.g., WASH. ADMIN. CODE § 388-271-0010-30 (Lexis-Nexis 2010); OR. REV. STAT. § 409.615-625 (2009); OR. ADMIN. R. § 333-002-0010 (2009). See also IND. CODE § 16-18-2-62 (2009) (describing the independent commission that was charged by the Indiana legislature to develop standards for training and practice for health care interpreters). See also Chen, *supra* note 43 (detailing the steps some states took to create the certification program). North Carolina is listed as one of the states developing “credentialing for interpreters as a pre-condition for initiating Medicaid reimbursement.” *Id.*

⁹⁹ See *Policy Initiatives*, NAT’L COUNCIL ON INTERPRETING IN HEALTH CARE <http://www.ncihc.org/mc/page.do;jsessionid=180B9145460BFD1E64FFB45DB328F8F4.mc0?sitePageId=50909> (last visited Feb. 5, 2010). The NCIHC “works for the development and advancement of the medical interpreter as an integral part of the health care experience for limited English speaking patients.” *Id.* Some of the activities involve “[i]nteracting with governmental agencies to promote and advocate for the role of the health care interpreter; [w]orking with health care review and regulatory agencies in developing standards for the role of the medical interpreter and the medical interpreting process;” and “[a]cting as a resource to local advocacy groups in promoting professionalism in medical interpreting.” *Id.* It is noteworthy that the Council is a major force behind the push for national certification.

¹⁰⁰ *Id.*

B. Other Legal Considerations

1. Patient Rights

a. Right to Autonomy and Self-determination

The concept of “patient rights” and related legislation is relatively new; however, all states “have enacted some form of health care law addressing” the issue.¹⁰¹ The right to autonomy and self-determination, the right to privacy with respect to medical information, and the right to receive and not be refused treatment encompass the major areas of patient rights.¹⁰² Under the right to autonomy and self-determination, a patient’s right to “withhold or grant informed consent” with respect to the course of treatment is “considered one of the most important and fundamental [of these rights].”¹⁰³ Moreover, in a notorious case dealing with this issue, the Supreme Court held that “every person had a fundamental right to self determination with regard to refusing life-sustaining medical treatment.”¹⁰⁴ For a LEP patient to be able to fully exercise these rights, meaningful language access is essential.

b. The Right to Die

While the Supreme Court concluded in *Washington v. Glucksberg* that there is no constitutional right to die,¹⁰⁵ there are a few states that allow the initiation of medical techniques to accelerate the onset of death, known as euthanasia or physician-assisted suicide.¹⁰⁶ This area of law is far from settled and states around the nation

¹⁰¹ See Gale Cengage, *Patient Rights*, ENCYCLOPEDIA OF EVERYDAY LAW, (2003), <http://www.enotes.com/everyday-law-encyclopedia/patient-rights>. The author summarizes patients’ rights “into a few main categories: the right to autonomy and self-determination (which includes the related right to withhold or grant informed consent, the right to privacy concerning medical information, and the right to receive treatment (not be refused treatment).” *Id.* While “some hospitals refer to these collectively as a “Patient Bill of Rights,” ... there is no such “bill of rights” document per se, excepting a generally accepted but not mandated version prepared by the American Medical Association and frequently used by hospitals. *Id.*

¹⁰² See, e.g., 10 N.Y.C.R.R. §405.7(a)(7)(i)-(x), (b)(1) (LexisNexis 2010) (describing Patients’ Rights under the State Mental Hygiene Law, and having provisions specifically addressing the facility’s responsibility as to the provision of language access services to their programs and the procedures to ensure access). The constitutional issues faced by LEP mental health patients mirror those confronted by criminal defendants when it comes to exercising due process of law.

¹⁰³ Cengage, *supra* note 101.

¹⁰⁴ *Id.* (citing *Cruzan v. Commissioner, Mo. Dept. of Health*, 497 U.S. 261 (1990)). In *Cruzan*, after the refusal of *Cruzan*’s family’s request to remove her from life support, the hospital kept the patient on life support during an irreversible coma for nine years. Eventually, after profuse litigation, life support was disconnected and the patient was allowed to die naturally. “The horror of that scenario, combined with the high court’s recognition of a constitutional right of self determination, led to a flurry of state enactments of various laws permitting living wills or advance directives for health care.” *Id.*

¹⁰⁵ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

¹⁰⁶ See *Assisted Suicide Laws State By State*, <http://www.euthanasia.com/bystate.html> (last visited Feb. 10, 2010) (stating that currently “[o]nly the states of Oregon and Washington permit physician-assisted suicide”). *Id.* Assisted suicide is criminalized through common law

may move for the decriminalization of this practice, following the current trend of some Western countries.¹⁰⁷ Regardless of the ethical, moral and legal implications of a patient choosing to exercise this right, it is essential that physician-patient communication be flawless.¹⁰⁸ Requiring demonstration of a minimum standard of competence, via a federal certification, and having statutory guidance for the provision of the most competent interpreter available would ensure that a LEP patient choosing to exercise his or her right to die has full knowledge of the procedures and consequences and is able to participate meaningfully in the process.

2. Malpractice Actions

While health care facilities receiving federal funds are required to provide language access to LEP patients under Title VI, whether public or private,¹⁰⁹ all health care providers face potential civil liability for the failure to provide competent interpreters if such failure leads to a tort cause of action, such as lack of informed consent, breach of duty to warn, or improper medical care.¹¹⁰ A federal statute mandating the use of certified health care interpreters in federally funded facilities would provide an incentive to non-federally funded providers to adopt the statute and deter malpractice suits based on issues of language access. It is well settled in tort law that physicians have no duty to provide care to individuals unless they are under a contractual obligation or perhaps in emergency situations within a hospital setting.¹¹¹ On the other hand, physicians who voluntarily engage in the provision of treatment with negative outcomes may be subject to malpractice liability.¹¹² A health

in nine states, but five other states, including North Carolina, Utah, Wyoming, Ohio and Virginia, do not explicitly criminalize it. *Id.*

¹⁰⁷ See *Tread Carefully When You Help to Die*, ASSISTED SUICIDE LAWS AROUND THE WORLD, http://www.assistedsuicide.org/suicide_laws.html (last visited Mar. 15, 2010) (analyzing the results of a survey showing that “the Western world is moving gradually to allow assisted suicide for the dying and the incurable rather than to permitting voluntary euthanasia”).

¹⁰⁸ This is perhaps the most compelling illustration of why meaningful participation of a LEP patient in the decision-making process regarding health and treatment outcomes depends on the expertise of a language interpreter.

¹⁰⁹ See 65 Fed. Reg. 52762, 52765 (Aug. 30, 2000) (stating that

[a]ll entities that receive Federal financial assistance from HHS, either directly or indirectly, through a grant, contract or subcontract, are covered by this Rule. Covered entities include: (1) Any state or local agency, private institution or organization, or any public or private individual that; (2) operates, provides or engages in health, or social service programs and activities and that; (3) receives federal financial assistance from HHS directly or through another recipient/covered entity).

Id. This includes private physicians who treat patients under Medicare or Medicaid because they fall under “covered entities” under the rule. *Id.*

¹¹⁰ See Khanijou, *supra* note 10, at 869 (outlining the “potential civil penalties for failing to provide language assistance services”).

¹¹¹ *Id.*

¹¹² See, e.g., *Quadriplegic Gets Million-Dollar Settlement*, *supra* note 1 (illustrating how failure of communication due to language issues was the trigger to treatment that led to an eighteen-year-old to suffer life-long consequences. The malpractice suit was settled for over

care provider prescribing treatment or medication to a LEP individual risks civil liability should a misinterpretation or misunderstanding due to the language barrier lead to a negative outcome.¹¹³ Malpractice lawsuits resulting from lack of informed consent, improper medical care, and breach of duty to warn may be more prevalent because of the failure to provide competent interpretation services.¹¹⁴

a. Lack of Informed Consent

Current law stands for the notion that “to obtain a patient’s informed consent to one of several alternative courses of treatment, the physician should explain medically reasonable invasive and noninvasive alternatives, including the risks and likely outcomes ... even when the chosen course is noninvasive.”¹¹⁵ The failure to provide a competent language interpreter to a LEP patient may result in the failure to obtain the patient’s informed consent to proceed with treatment.¹¹⁶ Whether the physician proceeds with treatment relying on a bad interpretation or without obtaining voluntary consent after adequate disclosure, such violation of the consent requirements may increase exposure to civil liability for physicians and health care facilities.

b. Breach of Duty to Warn

Where a pharmaceutical product is only available by a prescription written by a physician, that physician has the duty “to inform himself of the qualities and characteristics of those products which he prescribes for or administers to or uses on his patients, and to exercise an independent judgment, taking into account his knowledge of the patient as well as the product.”¹¹⁷ By virtue of the Learned Intermediary Doctrine, the physician “acts as a learned intermediary between the patient and the prescription drug manufacturers by assessing the medical risks in light of the patient’s needs.”¹¹⁸ The failure to provide competent language interpretation may cause a communication gap between a LEP patient and a physician that prevents the physician from accurately assessing the medical risks of a

seventy million dollars.). Even from a cost-benefit analysis perspective, having a statute providing for competent interpretation not only will prevent others, like Ramirez, from spending the rest of their lives suffering, but it will significantly decrease the amount of money health providers and their insurance carriers have to pay in settlements or judgments.

¹¹³ *Id.* See also Rui Kaneya, *Ailing System: Hospitals, Clinics Lack Interpreters*, CHI. REP., (Sept. 18, 2007), available at: http://www.chicagoreporter.com/index.php/c/Cover_Stories/d/Ailing_System:_Hospitals,_Clinics_Lack_Interpreters (quoting the director of community services at Westlake Hospital when referring to the potential liability hospitals confront by failing to provide interpreters: “Misdiagnoses—and expensive malpractice suits resulting from them—could also be avoided by having interpreters, said Mireya Vera”).

¹¹⁴ Kaneya, *supra* note 113.

¹¹⁵ *Matthies v. Mastromonaco*, 733 A.2d 456, 457 (N.J. 1999).

¹¹⁶ Khanijou, *supra* note 10.

¹¹⁷ See *Wooderson v. Ortho Pharm. Corp.*, 681 P.2d 1038, 1052 (Kan. 1984) (holding that physicians are liable for certain prescription drugs by virtue of the Learned Intermediary Doctrine). See also *Edwards v. Basel Pharm.*, 933 P.2d 298 (Okla. 1997).

¹¹⁸ *Edwards*, 933 P.2d at 300.

particular patient. This also may prevent a patient from understanding the warnings and appreciating the risks of a particular medication, resulting in serious consequences, including death.¹¹⁹ Ensuring competent interpretation will prevent harmful consequences for LEP patients while decreasing physicians' and health care providers' civil liability exposure for the breach of duty to warn.

c. Improper Medical Care

While the failure to communicate does not necessarily result in improper medical care, the potential for misdiagnosis or the prescription of the wrong course of treatment increases.¹²⁰ Further, an inordinate amount of time waiting for an interpreter may lead to a negative outcome.¹²¹ These negative outcomes may translate into serious medical consequences for LEP patients and result in legal actions against physicians and health care providers for medical malpractice.¹²² The likely negative health outcomes for the failure to use a competent language interpreter, the waste of time and resources spent in "expensive and often unnecessary tests to fill the language gap in an effort to avoid liability,"¹²³ and the large settlements and litigation costs for malpractice actions¹²⁴ provide a financial

¹¹⁹ See, e.g., *California Seeks to Stop the Use of Child Medical Interpreters*, *supra* note 2 (reporting the case where a child was interpreting the warnings and instructions to follow with the prescribed medication for his mother, instead of a competent interpreter, and due to a mistranslation the mother ended up dying).

¹²⁰ See Kaneya, *supra* note 113.

¹²¹ See Marcus, *supra* note 79 (referring to the author's years as a medical student in Massachusetts, where he remembered "pediatricians who struggled to explain an emergency procedure to a young Spanish-speaking mother – and waited and interminably long time for an interpreter to show up). In the same article, the author makes reference to the Ramirez case cited in note 1, to exemplify how "interpreter errors can also put hospitals and physicians in legal jeopardy." *Id.*

¹²² Khanijou, *supra* note 10.

¹²³ *Id.* at 869. In an effort to reduce liability exposure, health care providers faced with gaps in communication, due to language issues, often end up running unnecessary diagnostic tests with a steep price tag, when utilizing the services of a competent interpreter would have saved time and money. *Id.* See also Guy Boulton, *Blue Cross to Disclose Prices*, MILWAUKEE – WISC. J. SENTINEL, (Jul. 8, 2008), available at: <http://www.jsonline.com/business/29443069.html> (reporting on some of the costs for diagnostic tests). The price tag for an MRI at some hospitals varies from \$1758.00 to \$2029.00, while "[t]he same test . . . costs \$406 to \$676 at imaging centers." *Id.* Even if taking the most conservative price, once other routine diagnostic tests and the hourly rate of physicians and technicians performing and reading these tests are added and compared to the cost of hiring a competent interpreter for a full day, the amount of money saved is significant. Note that the full-day rate for a court interpreter certified pursuant to 28 U.S.C.S. § 1827 is \$388.00, and that one interpreter can assist several LEP individuals in one day. See *Current Fees for Court Interpreters* <http://www.uscourts.gov/interpretprog/rates.html> (last visited Feb. 10, 2010). Based on these facts and considering that health care interpreters' fees are lower than court interpreters', a health care provider could be saving thousands of dollars a day by appointing or employing competent interpreters.

¹²⁴ See, e.g., *Quadriplegic Gets Million-Dollar Settlement*, *supra* note 1 (reporting a settlement of over seventy million dollars for a malpractice suit arguably arising from the misinterpretation of the word "intoxicado").

incentive to recipients and non-recipients of federal funds to embrace a federal statute governing health care interpreters.¹²⁵

C. Current Problems Due to Lack of Federal Statutory Guidance

1. Assessing Patients' Language Proficiency and Interpreters' Competence

In the states where no health care interpreter certification is available, and even in those states where there is a statute for the provision of interpreters, it is unclear and undefined who is charged with the responsibility of determining the need for a language interpreter.¹²⁶ Regardless of whether clerical or medical staff takes on this responsibility, the factual determination that a patient requires language services rests at the sole discretion of the personnel of the health care facility.¹²⁷ Likewise, once the language interpreter is present, medical personnel are charged with the responsibility of determining the interpreter's competence.¹²⁸ Unless there is an independent body that can guarantee a minimum level of interpreter competency, the risks associated with low quality interpretation will be present because health care facilities and medical personnel are ill-equipped to make these determinations.¹²⁹

a. Patient's Language Proficiency

Medical personnel who are not trained to assess language competence are unqualified to determine independently the English proficiency of a patient.¹³⁰ This may lead to instances where doctors or nurses presume that a patient is proficient enough to understand the treatment or instructions and fail to call upon the services of an interpreter, even when the patient requests one. The fact that a patient is able to answer basic, everyday questions is not equivalent to having a full understanding and command of the formal English language necessary for meaningful participation in a health care setting, and frequently the distinctions between the different levels of

¹²⁵ See Kaneya, *supra* note 113 (describing the use of competent interpreters by hospitals as "sound business" because of the decrease of exposure to malpractice lawsuits for medical misdiagnosis based on language issues).

¹²⁶ See, e.g., WASH. ADMIN. CODE § 388-271-0010-30. Note that, even though Washington State has a certification program and a statute for the provision of health care interpreters, it is unclear how the determination of the need for services will be made.

¹²⁷ Note that health care facilities have to develop a plan for language assistance but there is no specific guidance addressing the determination of whether a patient requires language services or not. The Department of Justice provides strategic planning to assist federal funding recipients in ensuring meaningful language access. The Interagency Working Group on LEP, *Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance*, available at: <http://www.justice.gov/crt/lep/selfassesstool.htm> (last visited Mar. 15, 2010).

¹²⁸ The lack of a valid and reliable method to verify interpreter competence places this responsibility on medical personnel, who in large part are not qualified to make such determinations.

¹²⁹ See Romero, *supra* note 22, at 18 (explaining that in order to reliably make a language proficiency determination, a battery of tests is necessary).

¹³⁰ Note that this holds true for any field. Measuring and assessing language proficiency requires expertise and the use of valid and reliable methods of assessment.

proficiency a LEP individual may possess are overlooked.¹³¹ In the health care context, these distinctions may prove detrimental to the health outcomes of patients, when accurately describing symptoms, situations, and events, giving family history, and requesting clarifications to questions posed.

b. Interpreter's Competence

A related problem is the medical personnel's likely inability to assess the competence of the interpreter.¹³² In the first place, medical personnel who are not fluent in the language to be interpreted cannot independently evaluate the interpreter's fluency in the given language. Secondly, even if the interpreter is able to converse fluently with the patient, many doctors and medical staff mistakenly believe that bilingualism is a sufficient prerequisite for interpreting.¹³³ It is well established that health care facilities frequently use persons randomly to serve as interpreters, with little or no investigation as to their competence.¹³⁴ Not only is the patient's health jeopardized by allowing medical personnel untrained in the assessment of language competence to assess an interpreter's competency, but issues of a patient's right to privacy may also be at stake.¹³⁵ Certified interpreters, on the other hand, would be able to ensure confidentiality and avoid any actual or perceived conflict of interest.¹³⁶

¹³¹ Romero, *supra* note 22, at 18 (stating that “[f]or single language speakers, it may be difficult to determine how fluent a bilingual person is by listening alone. The only way to know for sure is to subject these individuals to a battery of tests in order to measure their bilingual ability.”) To determine that a patient is proficient enough to forego the assistance of a competent interpreter may increase a physician's or health care facility's exposure to liability based on misdiagnosis.

¹³² *Id.* at 21.

¹³³ *Id.* (exploring the levels of bilingualism and common misconceptions about proficiency in a foreign language).

¹³⁴ Khanijou, *supra* note 10, at 877 (discussing how patient “family [members] and other untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers and volunteered answers”). It also describes how untrained interpreters do not understand the need to interpret everything that is said by the parties and how family members may add their opinions and observations and end up imposing “their own values and judgments as they interpret or desire to shield the patient from negative embarrassing news.” *Id.*

¹³⁵ See Nat'l Law Health Program, *supra* note 84, at 43 (indicating that “many patients will not disclose sensitive or private information to family members and friends”). This will turn into incomplete information preventing the correct diagnosing of a condition. *Id.* It also presents a persuasive example for the use of professional interpreter: “if a battered woman is brought to the hospital by her batterer who is then asked to interpret for her, the battered woman is not likely to reveal the scope and cause of her injuries.” *Id.*

¹³⁶ A certification program for health care interpreters, similar to The Court Interpreters Act, would ensure that all certified interpreters know, and practice according to, a code of professional responsibility. The NCIHC has created a Code of Ethics for health care interpreters outlining the professional conduct and responsibilities of the interpreter's practice in the health care field. Confidentiality and avoidance of conflict of interests are outlined in the Code and any interpreter attempting to become certified must show proficiency and knowledge in the ethical standards before being granted the certification. See *National Code of Ethics for Interpreters in Health Care*, NAT'L COUNCIL ON INTERPRETING IN HEALTH CARE,

2. Costs and Efficiency of Using Language Services

a. Interpreters' Costs and Reimbursement Schemes

One factor that enhances the dilemma is that many health care facilities face strong perceived incentives to regard patients competent in the English language or to hold non-professional interpreters out as being competent so that no professional interpreter needs to be provided, even if the circumstances prove the contrary.¹³⁷ First is the issue of costs for the provision of interpreting services and the inadequacy of the current reimbursement scheme.¹³⁸ Medical interpreters' fees vary depending on many different factors, such as the language in question, the interpreter's qualifications and experience, and length of the services rendered, among other things.¹³⁹ While there are funds available to pay for language services for those health care providers receiving Medicaid and State Children's Health Insurance Program (SCHIP) funding,¹⁴⁰ the number of states willing to commit matching funds through their respective Medicaid programs is limited.¹⁴¹ At the same time, there are strong proponents who argue that other insurers, including the federal Medicare program, should provide funding for professional interpreters in order to improve the quality of care and reduce the risk of errors for LEP patients.¹⁴²

available at <http://www.ncihc.org/mc/page.do?sitePageId=98583&orgId=ncihc> (last visited Feb. 10, 2010).

¹³⁷ Note that the incentive to find that patients are sufficiently proficient in the English language and non-qualified interpreters competent is mainly based on costs. See Khanijou, *supra* note 10, at 873-74 (discussing both, costs for translation services and describing the reimbursement scheme). See also Peterson, *supra* note 87, at 1439 (discussing that "medical translators are costly, especially because [some] providers receive neither federal nor state reimbursement for providing services").

¹³⁸ Peterson, *supra* note 87.

¹³⁹ See, e.g., Khanijou, *supra* note 10, at 873 (describing that for a particular patient, the fees may run from \$30.00 to \$400.00 per hour, depending on the factors described). Having a federal statute regulating health care interpreters would mitigate some of these variations by establishing a statutory rate. This would provide consistency and predictability for federal funding recipients needing to provide interpretation services.

¹⁴⁰ See Mara Youdelman, *Medicaid and SCHIP Reimbursement Models for Language Services: 2007 Update*, NAT'L HEALTH L. PROGRAM, 1, 2, (2007) http://www.hablamosjuntos.org/newsletters/2007/July/pdf/Medicaid_SCHIP_20071.pdf.

¹⁴¹ *Id.* See also Chen, *supra* note 43, at 365 (describing that there are only twelve states and the District of Columbia participating in the reimbursement program). The states listed are Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Virginia, Washington, and Wyoming. The author mentions that "[w]hat is most notable about the states that are paying for interpreting for their Medicaid and SCHIP patients is that – with the exception of Hawaii- they all have small LEP populations." *Id.*

¹⁴² See Leighton Ku, *Paying For Language Services in Medicare: Preliminary Options and Recommendations*, CENTER ON BUDGET AND POLICY PRIORITIES, 1, (Oct. 2006), http://www.calendow.org/uploadedFiles/language_services_medicare.pdf (discussing the development of reimbursement systems for federal Medicare to pay for language services for elder LEP Americans in need of health care services.) It proposes a system of reimbursement based on the volume of LEP patients in the service area, as measured by Census data. *Id.*

It is noteworthy that while the costs of language services are undisputed, the requirement of competency associated with the language providers is addressed by less than a handful of states.¹⁴³

Given the indisputable demographical changes throughout the country, the appointment of certified health care interpreters would financially benefit health care providers in the long term, because competent interpreters preserve the integrity of the process, therefore preventing unintended health outcomes, avoiding unnecessary diagnostic tests, and reducing litigation costs.¹⁴⁴ A statute that provides specific competency requirements, a statutory rate for interpreting services, and incentives for states to adopt mechanisms for language service reimbursement, will positively affect the issue of access nationwide.

b. Process and Administrative Efficiency While Using Interpreters

Health care providers are sometimes reluctant to use interpreters because of concerns about efficient management of the workday, especially at times when facilities are overcrowded with patients.¹⁴⁵ These concerns arise in the contexts of both the management of the workload in general and the internal delays within individual patient examinations. When an interpreter is used for a medical examination, doctors must have advance notice so that an interpreter can be present; thus, any difficulty in obtaining the services of an interpreter can delay an examination,¹⁴⁶ causing further delays for the rest of the patients, resulting in time and financial inefficiency.¹⁴⁷ Within the context of the examination itself, the

¹⁴³ See Chen, *supra* note 43, at 365 (indicating that “only two states – Virginia and Washington – have specific provision for interpreter competency” and North Carolina is in the process of developing a certification program “as a precursor to reimbursement”).

¹⁴⁴ See Kaneya, *supra* note 113 (describing the use of competent interpreters by hospitals as “sound business” because of the decrease of exposure to malpractice lawsuits for medical misdiagnosis based on language issues). See also Khanijou, *supra* note 10, at 877 (describing how untrained interpreters “are prone to omissions, additions, substitutions, and volunteered answers and volunteered answers”). It also describes how untrained interpreters do not understand the need to interpret everything said by the parties and how family members may add their opinions and observations and end up imposing “their own values and judgments as they interpret or desire to shield the patient from negative embarrassing news.” *Id.* These type of situations destroy the integrity of the process.

¹⁴⁵ See Survey: *Hospital Overcrowding Issues Increase Over Last Year, According to Health Care Organization Executive*, BUS. WIRE, (Jan. 15, 2007), http://findarticles.com/p/articles/mi_MOEIN/is_2007_Jan_15/ai_n17115312/ (discussing a survey of 200 hospitals where “80 percent of respondents say overcrowding is one of their top five management concerns”).

¹⁴⁶ See Anne Harding, *Hispanics Face Longer Wait for Emergency GI Care*, REUTERS, (Aug. 6, 2009), <http://www.reuters.com/article/idUSTRE5755XT20090807> (reporting how medical examinations are delayed in order to obtain the services of interpreters).

¹⁴⁷ See Kristen Gerencher, *When English Becomes a Barrier to Care, Demand for Medical Interpreters Booming as Demographics Shift*, WALL ST. J. MARKET WATCH, (Nov. 5, 2009), <http://www.marketwatch.com/story/demand-for-medical-interpreters-is-booming-2009-11-05?pagenumber=2> (quoting Dr. Eric Hardt, medical consultant to interpreter services at Boston Medical Center, “that appropriate [interpreter] services could reduce health-care disparities and inefficiencies such as the number of patients who make repeat trips to the

presence of an unqualified interpreter harms the efficiency of the entire process.¹⁴⁸ Likewise, when the procedure for determining the language of a patient is inconsistent, the chances of pairing interpreters and patients that speak different dialects is likely to increase, further contributing to overall inefficiency.

While using a qualified interpreter causes a slight delay by virtue of the language processing, the overall efficiency remains intact.¹⁴⁹ When considering the costs of having doctors, nurses, patients, and other medical personnel rescheduled because of the appointment of an unqualified interpreter, or no interpreter at all, plus the administrative and possible human costs, the financial burden and inefficiency arguments of using a language provider fail. Enacting a statute outlining the steps that health care providers can take to minimize costs and increase process and administrative efficiency will positively impact language access in health care.

3. Maintaining a Uniform Language

a. *The “They Should Learn English” Approach*

Many born and naturalized Americans, as well as health care providers, justify denying language access to LEP individuals by reasoning that there is a state interest in maintaining a uniform language.¹⁵⁰ Some are of the opinion that there are policy reasons for giving residents an incentive to learn English.¹⁵¹ However, denying language access to health care services is not an adequate means to that end because it “places an enormous burden on the non-English speakers, with little countervailing benefit to society.”¹⁵² Non-English speakers hardly find these measures to be an

emergency room because their original problem wasn't handled properly.”) Note that the financial consequences logically follow such inefficiencies in the health care system.

¹⁴⁸ An unqualified interpreter is likely to create delays during the actual examination by asking for repetitions and trying to find the equivalent units of meaning from the source language into the target language and vice-versa. Certified interpreters would be able to utilize the mode of interpretation most efficient for the situation, whether using the simultaneous mode, or the consecutive mode. The entire process would guarantee accuracy and time efficiency.

¹⁴⁹ *Id.*

¹⁵⁰ See Daniel J. Rarick, *Reaching Out to the Most Insular Minorities: A Proposal for Improving Latino Access to the American Legal System*, 39 HARV. C.R.-C.L. L. REV. 543, 545, (2004) (discussing the movement initiated by some Americans out of fear of being subjected to other languages and cultures to “establish English as the official language of the United States in order to prevent government functions and services from being offered [in other languages]”).

¹⁵¹ See Steven W. Bender, *Impact of English Language Movement on Consumer Protection Regulation*, excerpted from *Consumer Protection for Latinos: Overcoming Language Fraud and English-Only in the Marketplace*, 45 AM. U. L. REV. 1027-348, 1047-1054 (1996), available at: <http://academic.udayton.edu/race/02rights/engonly3.htm> (stating that “one of the primary policy arguments made in favor of Official English (and English-Only) laws is that a multilingual government encourages immigrants to forego acquisition of English”).

¹⁵² Baker, *supra* note 83, at 606.

incentive because they do not plan their language learning motivation on the slight chance that they will have to use it in a hospital or health care facility.¹⁵³

On the other hand, the potential cost to a LEP individual, if a qualified interpreter is not provided, can be devastating. Not only are negative health outcomes likely when there is a gap in communication between doctors and patients, but there is also the potential for serious non-health related consequences, such as losing custody of one's child, should the need for the intervention of other professionals, such as a hospital social worker, be required.¹⁵⁴ Another scenario where a lack of competent interpretation may result in life-changing consequences for LEP patients is when the suspicion of criminal activity arises during a medical examination.¹⁵⁵ Misinterpretation of facts leading to a hospital visit may end up in the filing of unfounded criminal charges or the foregoing of an investigation of a potential crime.¹⁵⁶ The failure to learn English should not be punishable with the denial of services or programs from health care facilities receiving federal funds, resulting in an increased likelihood of negative health outcomes and deprivation of legal rights.¹⁵⁷

D. Policy Considerations

This section discusses some of the policy matters that the enactment of a federal statute would create. Even though some specific recommendations are made, in most instances this writing merely identifies factors that Congress should consider as a

¹⁵³ *Id.*

¹⁵⁴ See Tim Padgett, *Can a Mother Lose Her Child Because She Doesn't Speak English?*, TIME, Aug. 27, 2009, <http://www.time.com/time/nation/article/0,8599,1918941,00.html> (discussing the case of a mother who is in the process of losing custody of her daughter because the hospital where the mother was seen was not able to find a language interpreter for her native dialect and instead allowed a Spanish speaking social worker to interview her in Spanish). The miscommunication in this case led the social worker to suspect child endangerment and had the state intervene taking custody of the child. *Id.* The outcome of his case is still pending, but it helps illustrate the importance of having a system in place to address language access issues. *Id.*

¹⁵⁵ See *Legal Momentum, People Who Should Not Interpret in Domestic Violence and Sexual Assault Cases*, WESTERN N. Y. L. CENTER, <http://www.google.com/search?q=family+members+as+interpreters+domestic+violence&ie=utf-8&oe=utf-8&aq=t&rls=org.mozilla:en-US:official&client=firefox-a> (last visited: Mar. 15, 2010) (describing how a potentially criminal case may go unchecked when using an untrained interpreter, such as a family member, who turns out to be the actual perpetrator); *LEP Women and Domestic Violence Online Resource Center*, EMPIRE JUSTICE CENTER, (Sept. 16, 2010), http://onlineresources.wnylc.net/pb/orcdocs/LARC_Resources/LEPTopics/DV/DV.htm; Grace Huang, *Language Access and Survivors of Domestic Violence*, Washington State Coalition Against Domestic Violence, http://www.nrcdv.org/dvam/docs/materials/09-resource-packet/Issue_Articles_Newsletters/GraceLanguageAccess.pdf. (last visited Sept. 16, 2010).

¹⁵⁶ Huang, *supra* note 155.

¹⁵⁷ See, e.g., Padgett, *supra* note 154. See also *Legal Momentum, People Who Should Not Interpret in Domestic Violence and Sexual Assault Cases*, *supra* note 155 (describing how a sexual assault or a domestic violence incident may go uninvestigated if an untrained interpreter is the conduit of communication between the LEP patient and the medical personnel).

foundation for a health care interpreter statute without suggesting a particular course of action. Note that the issue of interpreters for the hearing impaired is not discussed, since legal actions based on the failure to provide a sign language interpreter are generally brought under the Americans with Disabilities Act.¹⁵⁸

1. A Health Care Interpreter Statute

As discussed above, current federal law, namely Title VI and Executive Order 13166, requires health care providers who receive federal funds to ensure meaningful language access for LEP individuals to their services and programs.¹⁵⁹ The current regulations, however, are insufficient in a number of areas, including the strict enforcement of such regulations¹⁶⁰ and imposing a competence requirement for language providers.¹⁶¹ Furthermore, while the spirit of the regulations is to afford access on the basis of language, the factual evidence indicates that a vast majority of health care facilities are not complying with language access requirements.¹⁶² Even those health providers attempting to bridge the language access gap may fail because of the lack of minimum standards of competency requirements for language providers.

2. Right to an Interpreter

The United States Constitution is silent as to whether a right to a language interpreter exists.¹⁶³ Since the issue has arisen mainly in the judicial setting, the Supreme Court has deferred to the discretion of lower court judges to interpret the Court Interpreters Act.¹⁶⁴ While the Act ensures language access to the courts for criminal defendants, some of the rationales are applicable to LEP patients and access to health care.¹⁶⁵

¹⁵⁸ 42 U.S.C.S § 12101 (prohibiting discrimination against individuals with disabilities by places of public accommodations).

¹⁵⁹ 42 U.S.C. 2000d; Executive Order 13166 (Aug. 11, 2000).

¹⁶⁰ See Khanijou, *supra* note 10; see also National Council of La Raza, *supra* note 45 (both arguing that current regulations are not strictly enforced).

¹⁶¹ Current regulations for language access do not provide for a minimum level of competence for language providers.

¹⁶² See Speaking the Language of Care: Language Barriers to Hospital Access in America's Cities, available at: http://www.comm.ohio-state.edu/pdavid/.../docs/Language/National_report.pdf (last visited: Oct. 20, 2010) (describing a study finding that despite the current federal laws and regulations providing for language access, "56% of Spanish speaking callers found that they could not reach anyone who spoke Spanish...[and from those] who visited hospitals, almost 60% could not find a Spanish speaking staff person to help them").

¹⁶³ The context in which this issue has been analyzed is the criminal justice system. See *United States v. Johnson*, 248 F.3d 655, 663 (7th Cir. 2001) (stating that "[t]he United States Supreme Court has yet to recognize the right to a court-appointed interpreter as a constitutional one." *But see* CAL. CONST. art. 1, § 14 (providing a constitutional right to an interpreter). "A person unable to understand English who is charged with a crime has a right to an interpreter throughout the proceedings." *Johnson*, 248 F.3d at 663.

¹⁶⁴ *Id.*

¹⁶⁵ See rationales applied to criminal defendants that could be applied to LEP patients, *supra* Part III.

3. Access

Policy makers must first determine whether enacting a statute regulating interpreters would contradict any of the current regulations regarding language access, as well as whether the statute would impose requirements on non-recipients of federal funds or should be limited to recipients outlined in the current regulations. On the issue of access, funding will play the most significant role, and policy makers should consider reforming current reimbursement schemes for language providers and explore the adoption of new funding schemes involving individual states.¹⁶⁶ Another consideration is whether language interpreters would be provided to all LEP patients regardless of their financial status, or whether access to a federally funded language provider would be limited to patients below the poverty line established by the federal government.¹⁶⁷ Clearly, providing language interpreters to all LEP patients will result in more costs than providing services only to those who qualify under federal poverty guidelines.¹⁶⁸ While Congress may have a justification for providing competent interpreters only to LEP patients below the federal poverty line, policy-makers must balance these financial concerns against the potential negative health outcomes and increased exposure to liability from allowing the use of privately funded interpreters that will not be required to comply with minimum standards of competency.

Next, the new statute should consider whether medical personnel should have the authority to deny the use of a language interpreter based on the patient's English language proficiency, and if so, what factors a health care provider must consider in making this determination. Health care providers have an obvious financial interest in avoiding the waste of providing funding for interpreters on behalf of patients who are sufficiently proficient in the English language. Furthermore, health care providers have an interest in the administrative efficiency of the services, which is arguably affected by utilizing the services of an interpreter when one is not needed. The new statute should outline the factors and provide a clear and reliable method to authorize the medical personnel charged with the administration of language services to deny the use of an interpreter for a patient, if such patient has sufficient proficiency in the English language.¹⁶⁹ In short, the denial of the services of a language interpreter should be proper only when it is clear that it would not benefit the patient and, if allowed, would negatively impact the administrative efficiency of the health care provider.

¹⁶⁶ See, e.g., Ku, *supra* note 142 (exploring the possibility of other reimbursement schemes for language providers, such as the federal Medicare program).

¹⁶⁷ See, e.g., Income and Resource Guidelines, *2010 Federal Poverty Guidelines*, CENTERS FOR MEDICARE AND MEDICAID SERVS., available at: http://www.cms.hhs.gov/MedicaidEligibility/07_IncomeandResourceGuidelines.asp (last visited Feb. 11, 2010).

¹⁶⁸ *Id.*

¹⁶⁹ This is a critical aspect of the new statute because the system in place to determine the English proficiency of the patient has to be valid and reliable enough to pass scrutiny, if it becomes a question for a court to decide.

4. Certification

The new statute must ensure that health care interpreters possess the training, preparation, and well-developed skills to effectively facilitate communication between health care providers and LEP patients. A federal certification program for health care interpreters would provide that assurance and guarantee that a minimum standard of competency has been met. Certification under the new statute would affirm that interpreters who pass the exams possess the minimum acceptable level of skill to function as health care interpreters.¹⁷⁰ This is necessary to secure the meaningful access required by current federal regulations and decrease the number of negative health outcomes due to lack of effective communication.

In considering the certification program, policy-makers should consider the availability of training programs.¹⁷¹ While there are some states that have implemented certification programs and a series of initiatives with respect to the certification of health care interpreters, a federal certification program would prove more beneficial in several respects.¹⁷² Policy-makers should encourage the

¹⁷⁰ Romero, *supra* note 22 (describing what certification programs require in the context of court interpreters). The discussion of certification programs of court interpreters is pertinent because the certification of health care interpreters would use the same format, with “written and oral examinations [to] assess the knowledge, skill, and ability necessary for effective ... interpretation.” *Id.*

¹⁷¹ Presently, interpreter-training programs vary widely throughout the country. In general, there appears to be little consistency among these programs with respect to the overall training and skill development of medical interpreters. There are a few formal college-based training programs for medical interpreters; however, should a statute be enacted requiring certification, it would provide an incentive for public and private colleges and universities throughout the nation to offer training programs. For example, in states where medical interpreters can obtain some sort of certification, some programs are currently available: Portland Community College’s Health Care Interpreter Training program in Oregon and Southern California School of Interpretation, Medical Interpreter program in California, to name a few. *See Health Care Interpreter Training*, PORTLAND COMMUNITY COLLEGE, available at <http://www.pcc.edu/climb/health/interpreting/training/> (last visited Sept. 16, 2010); *Medical Interpreting Program*, SOUTHERN CA. SCHOOL OF INTERPRETATION, available at http://www.interpreting.com/newwebpage/site_flash/index-1medical.html (last visited Sept. 16, 2010). These particular schools base their training programs on the skills and knowledge required to pass the certification exam, therefore standardizing the programs.

¹⁷² *See* Roat, *supra* note 14, at 87-88 (listing an array of benefits for implementing a national certification, as opposed to letting each state address the issue). Some of the reasons listed are:

A single, national certification makes it easier for consumers of interpreter services to understand what the credential represents. With multiple certifications available, it is difficult for consumers to compare credentials or to understand the strengths and limitations of each.

The existence of a national certification process circumvents the need for each state to set up reciprocity agreements with the certifying bodies of other states.

A national certification process is more likely to attract funding for test development. This may seem a mercenary consideration; however, while considering the cost of development of a valid a reliable testing instrument, the issue of funding should not be dismissed.

development of partnerships between health care providers and local colleges and universities, to develop training programs to ensure that enough individuals can get the required training and achieve certification.¹⁷³ Organizations like the NCIHC will be able to provide the necessary guidance and expertise to develop a sound certification program.¹⁷⁴

The final consideration with respect to implementing a new certification program is the price tag of such an endeavor. While the development and implementation of a valid and reliable certification program requires significant expenditure, there are some potential sources of funding that could offset the costs.¹⁷⁵ Initially, the court interpreter certification program, administered by the Administrative Offices of the Court, could provide invaluable resources, since the only major differences between both certification exams would be the content and ethical considerations.¹⁷⁶ Furthermore, “[g]rant funding could be sought for the initial development of the first test [and] there are a number of major foundations and federal government agencies that have demonstrated an ongoing interest in advancing the cause of language access.”¹⁷⁷ Finally, just like most certifications and licensures of this kind, a reasonable certification fee should be charged which, in turn, would help offset the cost of implementation.¹⁷⁸

5. Statutory Framework

As identified earlier, the Court Interpreters Act of 1978 can provide the administrative framework for a model statute regarding medical interpreters.¹⁷⁹ In the new statute, the Director of the DHHS would be charged with the establishment and administration of a program to facilitate the use of certified and otherwise

Id.

¹⁷³ This would not only benefit health care providers by increasing the pool of interpreters they can utilize, but it would also benefit colleges and universities financially by creating and offering new programs and attracting a diverse student body.

¹⁷⁴ See Roat, *supra* note 14, at 88-90 (providing a thorough analysis of the development of a national certification program).

¹⁷⁵ *Id.* at 88.

¹⁷⁶ Note that the logistics and interpreting skills required by both court and health care interpreters are largely the same. These would include testing the modes of interpretation consisting of simultaneous, consecutive and sight translation modes. The only difference would be the content area, where extensive knowledge of medical terminology and medical procedure is tested specifically for health care interpreters, and the code of professional conduct, which also differs from that of court interpreters.

¹⁷⁷ See Roat, *supra* note 14, at 90.

¹⁷⁸ See, e.g., *Exam Dates and Locations*, FEDERAL COURT INTERPRETER CERTIFICATION EXAMINATION, available at http://www.ncsconline.org/D_RESEARCH/fcice_exam/locations_dates.htm (last visited Feb. 12, 2010) (As of Feb., 2010 website listed the registration fee to take the examination at \$140.00). See also Nebraska Association of Translators and Interpreters, available at: <http://www.natihq.org/Default.aspx?pageId=353817> (last visited Oct. 22, 2010) (also listing the fee to take the examination at \$140.00).

¹⁷⁹ 28 U.S.C.S § 1827.

qualified interpreters in health care settings where federal funding recipients are involved in the delivery of health services.¹⁸⁰ The Director would also maintain a current master list of all certified and otherwise qualified interpreters, and prescribe, subject to periodic review, a schedule of reasonable fees for services rendered by interpreters, certified or otherwise.¹⁸¹

IV. CONCLUSION

Unhindered communication is the fundamental pillar in the physician-patient relationship. Any gaps in communication have the potential to result in misdiagnosis or misunderstandings of treatment prescribed by physicians and other medical personnel. As the non-English speaking population of the United States has increased, the gap in communication between linguistic minorities and health care providers has become more evident. Current regulations ensuring interpreter access for language minorities are unenforceable and have become a burden to health providers as well as LEP patients. Compounding the problem, the lack of national standards for health care language interpreters increases the likelihood of misdiagnosis and miscommunication.

In the past, Congress has recognized the need to provide language minorities with access to fundamental services and programs, whether by including language access provisions to protect the health and safety of children via The Food Stamp Act,¹⁸² or by allowing language minorities representation in our democracy via The Voting Rights Act.¹⁸³ More akin to the issue of language access to healthcare, The Court Interpreters Act of 1978 provides LEP criminal defendants with the right to fully participate in the process by implementing a certification program where interpreters have to prove a minimum standard of competency. It is imperative that Congress addresses the issue of language access in health care by enacting a statute for the certification of health care interpreters. Failure to address this issue will perpetuate the practice of allowing LEP patients to remain uninformed observers of their own health issues and treatment. Congressional action will help prevent unnecessary life-long consequences and death in cases like those of Willie Ramirez, Moon Chul Sun, and Griselda Zamora.¹⁸⁴

¹⁸⁰ In the Court Interpreters Act, "The Director of the Administrative Office of the United States Courts" is charged with the establishment of the program. 28 U.S.C.S. § 1827(a). In the proposed Health Care Interpreter Statute, the Director of the Health and Human Services would be charged with the responsibility to establish the program.

¹⁸¹ 28 U.S.C.S. § 1827(b)(3). These are requirements that the Director of the Administrative Office of the United States Courts must comply with and could be directly applicable to the new statute.

¹⁸² 7 U.S.C.S. § 2020.

¹⁸³ 42 U.S.C.S § 1971.

¹⁸⁴ See generally *Quadriplegic Gets Million-Dollar Settlement*, *supra* note 1; Daly, *supra* note 3; Scioscia, *supra* note 5.