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Best Methods for Increasing Medical Translators for Limited English Proficient Patients: The Carrot or the Stick?

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BEST METHODS FOR INCREASING MEDICAL TRANSLATORS
FOR LIMITED ENGLISH PROFICIENT PATIENTS: THE
CARROT OR THE STICK?

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I. INTRODUCTION

Dr. Jeffery Kerr’s situation exemplifies the current state of physicians who accept Medicaid and Medicare in rural communities and are struggling to keep their doors open in light of new cuts in federal and state spending.¹ He is currently one of the only physicians in the rural town of Houston, Missouri, who will see patients in a nursing home because a majority of the residents depend on Medicaid or Medicare to

¹Aaron Deslatte, *Medicaid Cuts Will Hurt Rural Areas*, NEWS-LEADER, (Springfield, Mo.) Feb. 21, 2003, at A14.

pay for their health care.² Dr. Kerr is worried that he, like other physicians before him, may have to stop seeing these patients or move to a different location because of reduced Medicaid reimbursements by the state.³

Like other physicians in town, Dr. Kerr feels that the current payments for Medicaid patients are break even at best. Dr. Honeywell, another physician who accepts both Medicare and Medicaid patients stated, "I'd be better off just sitting at home."⁴ This sentiment stems from the fact that it costs physicians, like Drs. Honeywell and Kerr, forty-eight dollars an hour in overhead expenses to treat an average of three patients, while Medicaid currently reimburses only twelve dollars per patient, minus the two dollars and ninety-one cents it costs to submit a claim through mail.⁵

Because Drs. Kerr and Honeywell accept Medicaid and Medicare, they are subject to the guidelines of the Department of Health and Human Services for the treatment of patients who are deemed to be limited English proficient ("LEP").⁶ These guidelines require physicians to hire trained medical interpreters for their LEP patients, and pay for these translators out of their own pockets.⁷

In August 2000, President Clinton issued an executive order mandating every federal funded program to prepare a plan to increase access to the programs for LEP individuals.⁸ Dr. Kerr will have to do the following in order to comply with the plan developed by the Department of Health and Human Services: 1) assess the needs of the community where he is practicing to determine the number of LEP patients; 2) develop a comprehensive written guideline on ways to ensure meaningful communication to LEP patients; 3) train his staff on the policy and ways to carry it out; and 4) vigilantly monitor his program, including reassessing the needs of the community in a timely manner.⁹ In order to satisfy the language access requirement, Dr. Kerr must also pay for medically trained translators out of his own pocket for all of his LEP patients, not just those patients enrolled in a government sponsored program like Medicaid or Medicare.¹⁰

Private physicians struggle to provide translators for patients, especially in rural areas like the one in which Dr. Kerr practices. Translators cost anywhere from thirty dollars to four hundred dollars depending on such factors as the time needed to

²*Id.*

³*Id.*

⁴*Id.* at A15.

⁵*Id.*

⁶*See* REVISED GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AFFECTING LIMITED ENGLISH PROFICIENT (LEP) PERSONS, 68 Fed. Reg. 47311, 47313 (filed Aug. 6, 2003), available at <http://www.hhs.gov/ocr/lep>, last visited Jan. 23, 2004 (hereafter "REVISED GUIDANCE").

⁷*See id.*

⁸Exec. Order No. 13166, 3 C.F.R. 289 (2001), reprinted in 42 U.S.C. 2000 d-1 (2000).

⁹*See* REVISED GUIDANCE, 68 Fed. Reg. at 47320-21.

¹⁰*Id.* at 47313.

translate, whether or not the translator is trained as a medical translator, and the language that is being translated.¹¹ Telephone language lines, which provide translation over the phone through a dial up service, costs providers an average of two dollars and fifty cents (\$2.50) per minute.¹² There is also the price of the extra personnel time that is required to develop, conduct training, and administer the physician's LEP program. Additional costs would include the following: researching the needs of limited English proficient patients in an area; translating medical literature; evaluating the plan; and reassessing the needs of the community to ensure the program's success.

Advocates of patients with LEP argue that there is a need for greater enforcement of existing guidelines, including adding a private right to sue.¹³ However, this will not assist LEP patients in rural areas where physicians simply cannot afford to follow these guidelines. More money needs to be spent on programs that already have been proven to be successful in these areas without placing additional burdens on physicians.

Part II of this article looks at the difficulties that patients who are limited in their English proficiency face in health care systems. Part III examines the history of Title VI and its use to end discriminatory practices in the health care system. Part IV analyzes the most recent and controversial Supreme Court decision regarding a disparate impact case brought under Title VI. Part V examines the limits of a private right to sue for assisting LEP patients, and Part VI presents some better solutions to this difficult problem.

II. PROBLEMS OF LIMITED ENGLISH PROFICIENT PATIENTS

In the movie *Lost in Translation*, an American actor is hired to shoot a whiskey advertisement for a Japanese company, and a translator is used for the filming.¹⁴

¹¹Allison Keers-Sanchez, Commentary, *Mandatory Provision of Foreign Language Interpreters in Health Care Services*, 24 J. LEGAL MED. 557, 573 (2003). This commentary focuses on the burden the government places on physicians to supply medical translators to LEP patients, including liability issues and cost issues. It also suggests some solutions to these problems at the end of the article.

¹²Mona T. Peterson, Note, *The Unauthorized Protection of Language Under Title VI*, 85 MINN. L. REV. 1437, 1474 (2001). This article argues that the Department of Health and Human Services has unconstitutionally exceeded its authority in issuing its policy guidelines that prohibit practices that have a disparate impact on minorities.

¹³Barbara Plantiko, Comment, *Not-So-Equal Protection: Securing Individuals of Limited English Proficiency with Meaningful Access to Medical Services*, 32 GOLDEN GATE U. L. REV. 239, 254 (2002). The author argues that plaintiffs will have much more difficulty suing physicians privately because of the new requirement of showing intentional discrimination, and they will have no remedy for practices that are neutral on the surface but nonetheless have a discriminatory impact on non-English speaking patients. See also Sara Rosenbaum and Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigoration the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL'Y, L. & ETHICS 215, 244 (2003). The authors argue that the Department of Justice is unable to enforce the guidelines of the Health and Human Services and that the threat of private litigation is needed to ensure compliance.

¹⁴Heartbreak Hotels, THE NEW YORKER, Sept. 15, 2003, at 100; LOST IN TRANSLATION (Focus Features 2003).

After the director gives an animated, long-winded speech, the translator interprets his direction to the actor with only two words: “more intensity.”¹⁵ While this was a comical part of the film, in the medical world the results of mistranslation can be deadly.

One instance where mistranslation can be deadly for patients who are limited English proficient (“LEP”) is when a physician attempts to diagnose a patient.¹⁶ Often, physicians rely on hand signals or gestures to figure out what is wrong with a LEP patient if a translator is not available.¹⁷ This reliance leads physicians to mistake symptoms of one disease for another and they may order incorrect treatments as a result.¹⁸ For example, in one case, a thirteen-year-old Hispanic girl, who was not English proficient and did not have an interpreter, died of a ruptured appendix.¹⁹ The treating physician gave the girl a pregnancy test, mistakenly believing this was the cause of her stomach pain; the girl later died of a ruptured appendix.²⁰ Had the physician been able to better communicate with the patient, it is possible that the right test could have been ordered, and she would not have died.²¹ Cases like this have raised awareness about the lack of qualified medical interpreters for LEP patients.

Sometimes LEP patients are forced to use translators who are not medically trained leading to other problems in getting adequate medical treatment.²² For example, some patients have their children or family members translate for them. Unfortunately, children make inadequate translators because “they are prone to omissions, additions and guessing.”²³ Using family members as translators can also result in confidentiality issues.²⁴ A patient may not divulge important information to a physician when a translator is a family member because of privacy concerns, and family members are less likely to be trained with medical translation and may not know terminology that is specific to the medical field.²⁵ Family members may even censor the information they are told by the physician when they substitute their own judgment for that of the doctors, “such as deciding grandma doesn’t need to know she’s dying.”²⁶

¹⁵*Id.*

¹⁶Keers-Sanchez, *supra* note 11, at 572.

¹⁷Franklin v. District of Columbia, 960 F. Supp 394, 410 (D.C.D.C. 1997), *rev’d in part, vacated in part by* 163 F.3d 625 (1999).

¹⁸Keers-Sanchez, *supra* note 11.

¹⁹Plantiko, *supra* note 13, at 240.

²⁰*Id.*

²¹*Id.*

²²*Id.* at 240.

²³*Id.*

²⁴REVISED GUIDANCE, 68 Fed. Reg. at 47318.

²⁵*Id.*

²⁶Tona Kunz, *Open to Interpretation Local Health Providers Seeking to Meet Community’s Diversity Needs*, CHICAGO DAILY HERALD, Aug. 1, 2003, at 1.

A recent study in the *Journal of Pediatrics* found that medical translators make a large number of errors, an average of thirty-one per session, with the most serious errors being made by non-professionals.²⁷ These errors have been classified as omission, addition, substitution, editorialization, and false fluency.²⁸ Omission is the most common error, accounting for about fifty-two percent of the errors in the study.²⁹

According to the 2000 Census Bureau, almost eighteen percent of American households speak a language other than English at home, and eight percent of Americans speak English less than very well.³⁰ Nineteen million Americans are considered to be limited in English proficiency.³¹ The growing number of non-native English speakers in America will greatly increase the need for medical translators in the future. For example, the Latino population is expanding at a rapid pace; projected to increase to a quarter of the U.S. population by the year 2050.³²

III. HISTORICAL OVERVIEW OF TITLE VI

A background of Title VI is needed in order to see the larger picture of how difficult it is to rely on physicians to privately fund medical translators.³³ While this law has been successful in eradicating the most blatant forms of discrimination in health care settings, it has been only moderately successful in ending practices that are neutral on the surface but still have a discriminatory effect.

Title VI prohibits federal agencies from discriminating against any person for a number of reasons including national origin, which includes discriminating against a person for speaking another language because language is closely associated with national origin.³⁴ Any private physician receiving federal funds is covered under the Act.³⁵ A vast number of private physicians accept Medicaid and Medicare and are prohibited from discriminating against patients because of their race, color, or national origin under the Act.³⁶ Title VI defines discrimination in two ways: 1) when a person excludes another from participation in a federal program or the benefits of the program because of their race, color, or national origin (disparate treatment); and

²⁷Garrot Condon, *Study Finds Problems with Medical Interpreters*, THE BATON ROUGE SUNDAY ADVOCATE, Feb. 2, 2003, at 13H.

²⁸*Id.*

²⁹*Id.*

³⁰U.S. Census Broad, Profile of Selected Social Characteristics: Census 2000 Supplemental Survey Summary Tables.

³¹Condon, *supra* note 27.

³²Steven P. Wallace and Valentine M. Villa, *Equitable Health Systems: Cultural and Structural Issues for Latino Elders*, 29 AM. J.L. & MED. 247, 249 (2003) (providing a comprehensive overview of health care issues that will arise from the rapidly expanding Hispanic, elderly population).

³³42 U.S.C. § 2000d.

³⁴Keers-Sanchez, *supra* note 11, at 562.

³⁵*Id.* at 563.

³⁶*Id.*

2) when an entity that has received federal programs has practices in places that effectively deny participants from fully participating in the program based on race, color, or national origin (disparate impact).³⁷

A. *Enforcement of Title VI*

Just as Title VII prohibits discrimination in the work force, Title VI prohibits discrimination by the federal government or those receiving funds from the government; but these two acts are enforced by Congress in separate ways. Title VII prohibits all employment discrimination via the commerce clause, while Title VI is authorized by Congress's power in the spending clause.³⁸ Because Congress relied on the spending clause to create Title VI, it does not have the power to prohibit discrimination by all physicians, only those physicians who accept federal money.³⁹ Title VI does not impose any obligation on physicians, but acts as a bribe. The physicians can either follow the guidelines set forth under Title VI and receive federal money, or not follow the guidelines and be excluded from government programs like Medicaid or Medicare.⁴⁰ However, once a physician accepts federal money, all his patients are covered by Title VI regulations, not just those patients who are using Medicaid or Medicare.⁴¹ The theory behind this enforcement scheme is that the funds that are provided go to benefit the enterprise as a whole.⁴² Because Title VI acts as a bribe to prevent discrimination, physicians will stop accepting Medicaid and Medicare patients if the conditions set forth by the Department of Justice to enforce Title VI are too expensive. As a result, the physicians will no longer be subject to these conditions, including providing translators for LEP patients.

B. *History of Title VI and Intentional Discrimination in Health Care*

Title VI was part of the 1964 Civil Rights Act designed to end intentional discrimination against minorities.⁴³ Prior to its passage, health care facilities blatantly discriminated against black patients by separating black patients in different wards to be treated by black physicians.⁴⁴

³⁷42 U.S.C. § 2000d.

³⁸Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 *FORDHAM L. REV.* 939, 944 (1990) [hereinafter *Title VI*] (addressing the relative ease in which defendants have succeeded in winning suits against plaintiffs claiming that the defendants' policies had a negative racial impact).

³⁹Rosenbaum & Teitelbaum, *supra* note 13, at 220.

⁴⁰Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 *AM. J.L. & MED.* 203, 214 (2001) [hereinafter *Race*] (urging the adoption of financial incentives to help reduce the number of errors committed in treating minority patients because of variations in patient's needs that are not currently being addressed in the medical field).

⁴¹Rosenbaum & Teitelbaum, *supra* note 13, at 223.

⁴²*Id.*

⁴³*See Race*, *supra* note 40, at 216.

⁴⁴*Title VI*, *supra* note 38, at 940.

In *Simkins v. Moses H. Cone Memorial Hospital*,⁴⁵ the Fourth Circuit Court was the first court to hold that hospitals were prohibited from discriminating against patients because of their race if they received federal funding. This case has been compared to *Brown v. Board of Education*,⁴⁶ but for health care instead of education.⁴⁷ Initially, this case had very little impact on health care facilities because very few facilities accepted federal money prior to the enactment of the Medicaid and Medicare programs.⁴⁸

The enactment of Medicaid was a crucial component in the successful eradication of the most blatant forms of discrimination in health care facilities. It was the promise of money, not the threat of litigation, that produced the quick and voluntary desegregation in hospitals.⁴⁹ The promise of federal money is at the core of Title VI because it is based on the government's spending power and not the commerce clause.⁵⁰

Medicaid was an incentive for hospitals to become desegregated in a short amount of time; they were given an option of either taking action to end intentional discrimination, or not being eligible for the federal assistance.⁵¹ At the time, Medicaid payments were "clear, strong, and unambiguous."⁵² More than ninety-two percent of hospitals were desegregated before Medicaid payments began as a direct result of the money that was promised.⁵³ The cost of desegregation was low: it involved taking down "white only" signs and moving patients from one segregated side to another so that black and white patients were in the same buildings and were sharing rooms.⁵⁴

When Title VI was first introduced by the legislature, it was used only to end the most blatant and obvious forms of discrimination in health care facilities.⁵⁵ These changes included ending practices of turning away minority patients or segregating patients based on race. But Title VI is now most often used when health care facility practices have an unintended negative impact on protected classes of individuals, although facially these practices are non-discriminatory.

⁴⁵*Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F. 2d 959 (4th Cir. 1963).

⁴⁶*Brown v. Board of Education*, 347 U.S. 483 (1954).

⁴⁷*Race*, *supra* note 40, at 212-13.

⁴⁸*Id.* at 214.

⁴⁹*Id.* at 213.

⁵⁰*Id.*

⁵¹*Id.* at 214. Hospitals had just four months to comply with the desegregation requirement when the Surgeon General notified them of this requirement prior to Medicare's start up.

⁵²*Id.* at 215.

⁵³*Id.*

⁵⁴*Id.*

⁵⁵*Id.* at 216.

C. *History of Title VI and Disparate Impact in Health Care*

Critics argue that Title VI has not been very successful in ending less obvious forms of discrimination in health care systems.⁵⁶ A lot of these practices are neutral on the surface, but have a negative impact on a class of people who are protected under Title VI, also known as disparate impact cases.⁵⁷ When a plaintiff challenges a practice that is neutral on the surface as being discriminatory in effect, she has the burden of proving that there was no justifiable business reason for the medical office to have that practice in place.⁵⁸ Courts have often allowed costs to be used by health care facilities as justifiable excuses. Professor Sidney D. Watson stated that:

the courts have also been sympathetic to hospital's cost concerns, articulating a legal standard for evaluating the health care providers non-discriminatory justification that is deferential to providers' cost concerns and less demanding than the standards used in case involving allegations of disparate racial impact in federally-funded education and private employment.⁵⁹

The first case that recognized a disparate impact caused by the lack of accommodation for people living in America with LEP was in the educational arena, *Lau v. Nichols*.⁶⁰ The Court held that although there was not intentional discrimination of Chinese students by the school, a lack of limited English proficient classes had a discriminatory effect on the students because they could not benefit from the education as well as English speaking pupils.⁶¹

A review of cases reveals that plaintiffs have been less effective in proving disparate impact cases in the medical setting. In order to be successful, plaintiffs claiming they were subjected to disparate impact under Title VI would first have the burden of showing that a facially neutral practice had a disproportionate impact on a class that was protected by Title VI.⁶² However, the medical facility could then produce a reasonable business necessity for the practice, most often cost.⁶³ The plaintiff would then have the opportunity to present less burdensome means of meeting that business necessity, without resulting in discrimination.⁶⁴ It has been suggested that courts decide disparate impact cases that fall under Title VI less critically than disparate impact cases that fall under Title VII.⁶⁵ Professor Sidney D. Watson wrote that "in the Title VI health care context a policy with a disparate

⁵⁶*Id.* at 217.

⁵⁷*Id.*

⁵⁸*Id.* at 218.

⁵⁹*Id.* at 219.

⁶⁰*Lau v. Nichols*, 414 U.S. 563 (1974). Lau's interpretation of § 601 has been rejected.

⁶¹*Id.* at 568.

⁶²Peterson, *supra* note 12, at 1452.

⁶³*Id.*

⁶⁴*Id.*

⁶⁵Title VI, *supra* note 38, at 966.

impact can be justified by showing merely that the policy is rationally related to a legitimate need,” criticizing the ease physicians had in defending disparate impact claims.⁶⁶

For example, in *Bryan v. Koch*⁶⁷, the court held that the defendant’s reason for closing a hospital, in order to save costs, was a justifiable business necessity. In this case, minority patients brought a Title VI action against the City of New York for the selection of its public hospital to be closed.⁶⁸ The plaintiffs showed that the particular public hospital that the City of New York had chosen to close served a large number of African American and Hispanic patients, so the closing of the hospital would have a disparate impact on this protected class of patients.⁶⁹ However, the court held that the City’s proffered reason, to save costs and make the hospital system more efficient, was enough for them to prevail, without conducting an analysis of the impact it would have on minorities.⁷⁰

The court also rejected the plaintiffs’ argument that there were other methods of saving money that would have a lower impact on minorities because “[t]he court feared that an alternatives inquiry that went beyond the question of which hospital to close would impinge upon elected officials’ discretion to run their city government.”⁷¹ In disparate impact cases brought under Title VI in the medical field, plaintiffs often have a hard time winning even when the plaintiffs show that there is a disparate impact and less discriminatory options to meet a legitimate end.⁷²

Another case that demonstrates the difficulty of winning a Title VI disparate impact suit is *NAACP v. Medical Center, Inc.*⁷³ In *Medical Center*, the plaintiffs opposed the removal of a hospital from the inner city that was composed of predominately black residents to a predominately white suburb of Wilmington, Delaware. The plaintiffs claimed that it would make it harder for minority and disabled patients to get acute care services because these services were not provided by other medical facilities in the area.⁷⁴ Like *Bryan*, the Third Circuit Court found that plaintiffs had met their initial burden of proof regarding the discriminatory outcome of a medically neutral practice.⁷⁵ Ultimately, the defendant prevailed because the court held that the defendant had met its burden by producing a rational reason for moving the clinic, and held that no other analysis was needed as a result.⁷⁶ This is another example of the court using minimum scrutiny to decide a Title VI

⁶⁶*Id.*

⁶⁷627 F.2d 612 (2d Cir. 1980).

⁶⁸*Id.*

⁶⁹*Id.*

⁷⁰Title VI, *supra* note 38, at 967.

⁷¹*Id.*

⁷²*Bryan v. Koch*, 627 F.2d 612, 620-21 (2d Cir. 1980).

⁷³Title VI, *supra* note 38, at 967.

⁷⁴*NAACP v. Medical Center, Inc.*, 657 F.2d 1322 (3d Cir. 1981)

⁷⁵*Id.* at 1326.

⁷⁶*Id.*

disparate impact case, where the defendant only needs to produce an economic rationale for a neutral practice that is proven to have a disparate impact to prevail.

Critics suggest that the rational basis test used by courts in determining whether a practice that has a discriminatory impact on minorities is justified by a business reason is too low of a standard.⁷⁷ These critics argue that the rational relationship test, which allows the defendant to provide a reasonable business need for a practice that has an adverse affect on a group of people, is almost akin to not having any sort of test at all and holding all policies valid.⁷⁸ Recently, more controversy surrounding Title VI disparate impact cases has surfaced because the Supreme Court held that an individual did not have the right to sue privately for these cases.

IV. THE CONTROVERSY REGARDING THE COURT'S HOLDING IN *ALEXANDER v. SANDOVAL*

Advocates for LEP patients have been critical of the Supreme Court for not allowing a plaintiff to bring a private action against medical providers for these neutral practices under Title VI.⁷⁹ Much of the criticism regarding Title VI's ineffectiveness in resolving disparate impact cases stems from *Alexander v. Sandoval*, where the Court held that Title VI did not provide plaintiffs with a private right to sue except in cases of intentional discrimination.⁸⁰

The plaintiffs in *Sandoval* sued because of the enactment of an Alabama state law that implemented an English only rule for the state's driver's license examination.⁸¹ The state asserted that it changed to the "English only" policy due to safety reasons: because all of the traffic signs are in English and presumably drivers that could not read them would be a danger to themselves and to others on the road.⁸² The plaintiffs argued that the policy change had a disparate impact on people of different national origins who were limited English proficient because the policy prevented them from securing a driver's license.⁸³ The state countered that the plaintiffs could not sue in a private action under Title VI because the plaintiffs complained of disparate impact, and not intentional discrimination.⁸⁴ The Court only decided the issue of whether or not there is a private cause of action to bring a disparate impact suit against defendants under Title VI.⁸⁵

The Court's opinion focused on two sections in Title VI: section 601 and section 602. Section 601 states that "no person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied the

⁷⁷Title VI, *supra* note 38, at 969.

⁷⁸*Id.*

⁷⁹Plantiko, *supra* note 13; Rosenbaum and Teitelbaum, *supra* note 13.

⁸⁰*Alexander v. Sandoval*, 532 U.S. 275 (2001).

⁸¹*Id.*

⁸²*Id.* at 279.

⁸³*Id.*

⁸⁴*Id.* at 275.

⁸⁵*Id.* at 279.

benefits of or be subjected to discrimination under any program or activity receiving federal financial assistance.”⁸⁶ In *Lau v. Nichols*, the Court reasoned that Title VI Section 601 could be used to bring a private action when plaintiffs feel that they have been prohibited from participating in a program receiving federal funds by a practice that has a disparate impact.⁸⁷ However, in this case, the Court reversed its decision and held that plaintiffs could only bring private claims under Title VI Section 601 when there is intentional discrimination.⁸⁸

The Court then analyzed Section 602 to determine whether a plaintiff could bring a private right of action for disparate treatment using this section of Title VI.⁸⁹ Section 602 was intended to allow federal agencies “to effectuate the provisions of [§ 601] . . . by issuing rules, regulations, or orders of general applicability.”⁹⁰ This section “asks various federal agencies to put into practice the anti-discrimination mandate of Section 601.”⁹¹ In *Sandoval*, the Court held that even if Section 601 includes intentional discrimination only, Section 602 does allow federal agencies to put policies in place to prohibit activities that have a disparate impact on protected groups.⁹² According to its holding, Section 602 gives agencies the right to prohibit disparate impact practices, and Congress did not intend for there to be a private right of action to enforce this section of Title VI.⁹³

The dissent in *Sandoval*, contained many of the same arguments that critics of the Court’s decision point out. There were four Supreme Court Justices who dissented: Stevens, Souter, Ginsburg, and Breyer. The dissent opinion argued that it was Congress’s intent to include a private enforcement right to disparate impact cases brought under Title VI, because this is the type of discrimination that would be included in Section 601 of the act, and because of previous court decisions under Title VI, in particular the Court’s decision in *Cannon v. University of Chicago*.⁹⁴

The dissent criticized the majority’s “uncharitable understanding” of the right of private action under Title VI because they misinterpret the congressional intent.⁹⁵ They argued that Congress did intend for Section 601 to give a private right to sue for disparate impact.⁹⁶

[B]oth Title VI and Title IX were intended to benefit a particular class of individuals, that the purposes of the statutes would be furthered rather

⁸⁶42 U.S.C. § 2000d (2001).

⁸⁷532 U.S. 275, 285 (2001).

⁸⁸*Id.* at 279. Court relies on its holding in *Alexander v. Choate*, 469 U.S. 287, 293 (1985), stating “Title VI itself directly reach[es] only instances of intentional discrimination.”

⁸⁹*Sandoval*, 532 U.S. at 286.

⁹⁰*Id.* at 278.

⁹¹Plantiko, *supra* note 13, at 246.

⁹²*Sandoval*, 532 U.S. at 281.

⁹³*Id.* at 286.

⁹⁴*Id.* at 297; *Cannon v. University of Chicago*, 441 U.S. 677 (1979).

⁹⁵*Sandoval*, 532 U.S. at 311.

⁹⁶*Id.* at 313.

than frustrated by the implication of a private right of action, and that the legislative histories of the statutes support that Congress intended such a right.⁹⁷

The dissent stated that Section 601 and Section 602 were not meant to divide the enforcement rights of Plaintiffs under Title VI, but the two sections rely on each other. Section 602, according to the dissent, was created for the sole purpose of “forwarding the antidiscrimination ideals laid out in [Section 601],” and these ideals necessarily included discrimination from disparate impact practices.⁹⁸

The dissent also took the holding from *Cannon* to prove that there is a private right of discrimination for disparate impact cases under Title VI. Although *Cannon* was brought under Title IX, the majority opinion noted that Title IX was instructive in deciding whether or not there was a private right to sue under Title VI, because Title VI was modeled after Title IX.⁹⁹ Therefore, once a private right to sue was found under Title IX, the Court also found that there would be one under Title VI. The majority and the dissent disagree regarding whether *Cannon* was private action under intentional discrimination or disparate impact.¹⁰⁰ The majority held that the plaintiff in *Cannon* proved she had been intentionally discriminated against by the Medical School at the University of Chicago because she was a woman.

The dissent argued that the plaintiff was rejected from the school because of its age requirement, and plaintiff successfully argued that this affected more women than men, because women took more time off before continuing their education to raise families than men.¹⁰¹ Therefore, the dissent argued that *Cannon* was actually a disparate impact case, and supported their opinion that Title VI should have private enforcement for disparate impact practices.¹⁰²

A lot of supporters for LEP patients have argued that reintroducing a private right of action would help provide more qualified medical translators.¹⁰³ However, this argument would only be logical if plaintiffs had been successful in changing neutral practices that had discriminatory effects when they had the private right to sue for these practices. There was never a significant correlation between the private right to sue and greater enforcement of Title VI, and the Department of Justice can still provide remedies for these types of cases.

V. REASONS GREATER PRIVATE ENFORCEMENT UNDER TITLE VI WOULD NOT ASSIST “LEP” PATIENTS IN RURAL AMERICA

Many scholars suggest harsher penalties and more enforcement of existing policies as a way to ensure adequate medical translators in the medical field.¹⁰⁴ The

⁹⁷*Id.* at 312.

⁹⁸*Id.* at 304.

⁹⁹*Id.* at 280

¹⁰⁰*Id.*

¹⁰¹*Id.*

¹⁰²*Id.*

¹⁰³Plantiko, *supra* note 13; Rosenbaum & Teitelbaum, *supra* note 13.

¹⁰⁴*Id.*

problem of providing qualified medical translators for patients who are LEP cannot be viewed in a vacuum, especially in rural areas where there is a shortage of health facilities. While the new guidelines have been successful in large urban hospitals, private physicians are struggling to pay for costs associated with patient care, let alone spending out of pocket money for costly translators.¹⁰⁵ More immigrants, especially Hispanic immigrants, are moving into these rural areas, which will place more burdens on physicians to procure translators.¹⁰⁶ Providing more government assistance to physicians practicing in underserved areas is the key to reaching the goal of helping LEP patients, not spending more money on the greater enforcement of existing guidelines.

Returning to a private enforcement of Title VI rights will not work to solve the problems that LEP patients face in rural America today, and neither will spending more money on the greater enforcement of existing guidelines. Despite what the critics of the Court's decision in *Sandoval* have said, LEP patients can still get help through administrative means, which is better because administrations work with the physician in getting all LEP patients the necessary assistance they need. In addition, even when there was a private right of action in disparate impact cases, the courts were very reluctant to award the patient damages when the physician could show that there was a legitimate reason, such as cost, for a neutral practice, that has discriminatory effects. The money that would be spent on greater enforcement would be better spent on practices that have already been shown to be effective.

In criticizing the idea of greater enforcement of medical translators for LEP patients in rural America, it should be noted that this paper does not propose the eradication of these guidelines, like the plaintiffs requested as a remedy in *Proenglish v. Bush*.¹⁰⁷ In fact, these guidelines have proven to be effective in larger cities, where hospitals have been able to use their resources in order to make their services more accessible to LEP patients.¹⁰⁸ Central DuPage Health Centers, which serve the greater Chicago area, currently see about 200 LEP patients a week.¹⁰⁹ In

¹⁰⁵See Victoria Colliver, *Crossing Language Barriers/ Videophones Help Hospital Provide Crucial Translation Services*, THE SAN FRANCISCO CHRONICLE, July 5, 2003, at 1B. The article describes the translator services available at Alameda County Medical Center, which has 18 full time translators. The hospital can afford to pay these translators around \$20 an hour for their services and notes that medical facilities who don't have full time translators may have to pay up to \$130 an hour for services. The article also notes that many private physicians do not provide medical translators to LEP patients because of cost.

¹⁰⁶Rebecca Rivas, *Hispanic Immigrants Often Rely On Clinics For Health Care*, APWIRE, May 30, 2003, at 16:54:00. There has been a steady increase in the number of Hispanics moving to rural areas for meatpacking jobs. The average increase in the Hispanic population in four rural southwest counties was 800 percent according to the 1990 census. Many Hispanic people living in rural areas have poor English skills and health care facilities had to find additional medical translation services as a result.

¹⁰⁷70 Fed.Appx. 84, 2003 WL 21101726 (4th Cir. 2003). Plaintiffs unsuccessfully sought an injunction against the Department of Health and Human Service's guidelines for providing aid to LEP patients. The court dismissed the plaintiffs' case because they could not show that they were harmed, or threatened with harm by the guidelines.

¹⁰⁸Kunz, *supra* note 26.

¹⁰⁹*Id.*

order to accommodate these patients, the Centers have hired three full time interpreters.¹¹⁰ Another hospital in Dupage County has installed two-way televisions set up to access foreign language interpreters, which allow the patient and interpreter to see each other.¹¹¹ Larger health care facilities in urban areas are able to afford expenses like setting up dial up interpreter services and training for certified medical translators.¹¹²

Unfortunately, smaller, private physician offices in rural areas lack the resources to spend on translators. Therefore, greater enforcement will not work for these physicians for two reasons: 1) the impact of greater enforcement would mean that even more physicians in these underserved areas would close their doors, and 2) even if plaintiffs could bring private actions, courts would most likely find the lack of resources to be justifiable.

A. Health Care Struggles in Rural America

One of the strongest arguments against greater enforcement of Title VI is that ultimately the LEP patients would suffer. Although the threat of litigation is a strong deterrent for businesses to limit discrimination practices, in most cases the threat is that the physicians will be cut off from federal funding.¹¹³ “Cutting off Medicare and Medicaid dollars is likely to be as hurtful to poor minority patients as the discrimination it seeks to redress.”¹¹⁴ The physicians in these areas are already getting less money from Medicaid and Medicare patients than health centers in urban areas, due to federal guidelines.¹¹⁵ These physicians are also prohibited from passing on costs to other patients who are privately insured because insurance companies have increasingly set guidelines for the amount of money they will pay for services.¹¹⁶

In Mississippi, doctors complained that reimbursement for Medicare and Medicaid is lower than the overhead cost of providing treatments for these patients.¹¹⁷ One doctor was quoted as saying, “[w]hen your costs exceed your income, you have a problem. This issue is on every doctor’s radar screen.”¹¹⁸ In other parts of the country, doctors expressed the same sentiment. In Alaska, one doctor complained about being reimbursed about \$.40 on the dollar, when it costs

¹¹⁰*Id.*

¹¹¹*Id.*

¹¹²*Id.*

¹¹³*Race, supra* note 40, at 219.

¹¹⁴*Id.*

¹¹⁵Melanie Brandert, *Rural States Could Get Medicare Relief*, ARGUS LEADER, Sept. 29, 2003, at 1A.

¹¹⁶*Georgia Physician Survey Called on Target, But Lacking Answers*, BEST’S INSURANCE NEWS, Jan. 30, 2003, available at 2003 WL 4279637.

¹¹⁷Becky Gillette, *Doctors, Patients Worried About Reimbursement Cuts*, MISSISSIPPI BUSINESS JOURNAL, Jan. 27, 2003, at 21.

¹¹⁸*Id.*

\$.65 on the dollar for overhead.¹¹⁹ The problem in both states is that the amount of money being paid for treatments in Medicaid's and Medicare's fee schedule has decreased, while many of the overhead costs for physicians have increased.

In an article written about the rising cost of medical care and the declining reimbursement for Medicare, Dr. Harold Johnston, director of the Alaska Family Practice Residency of Providence Alaska Medical Center in Anchorage, stated that although overhead costs for physicians have risen about 15% over the past two years, Medicare reimbursement has been reduced by 10% between 2002 and 2003, "and the sum is a 35% discrepancy between payment and cost."¹²⁰

Dr. Donald J. Palmisano, President of the American Medical Association, has criticized Medicare because the system, with the new 2004 cuts, is causing physicians to stop seeing Medicare patients because "every time they see one, they'll lose money."¹²¹ Because of this discrepancy, many physicians are opting out of Medicare voluntarily.¹²² There is no law that says that physicians have to accept Medicare or Medicaid payments, and if they opt out there is no enforcement under Title VI.

Even if a private right to sue for disparate impact under Title VI were allowed, if physicians failed to follow Department of Justice Guidelines, it would still not help LEP patients in rural areas because an increasing number of these physicians are either opting to not participate in Medicaid and Medicare due to the fee schedule, or are moving to more urban areas where there is an increased fee schedule and a lower number of Medicaid and Medicare patients.

B. The Growing Number of LEP Patients in Rural America

While private physicians are struggling to keep their doors open in smaller rural areas, these same areas are rapidly growing in the number of immigrants living there, especially immigrants from Mexico who are attracted to the agricultural and meatpacking jobs that are available.¹²³ Since 1990, many small towns have had a dramatic increase in their settlement of Latinos.¹²⁴ For example, towns like Noel, Missouri and Postville, Iowa have seen an almost 50% rise in their Latino populations.¹²⁵ The biggest growth in Latino populations in the U.S. is in rural areas,

¹¹⁹Deborah J. Myers, *The Medicare Dilemma: Medicare Reduced the Amount of Money It Will Reimburse for Medical Treatment and Many Doctors Are Opting Out of Taking Medicare Patients as a Result*, ALASKA BUSINESS MONTHLY, Apr. 1, 2003, at 84.

¹²⁰*Id.*

¹²¹Joyce Frieden, *Medicare Payments Could Drop by 4.2% in FY 2004: Congress Left Underlying Fee Formula Intact*, SKIN & ALLERGY NEWS, May 1, 2003, at 1.

¹²²Gillette, *supra* note 117.

¹²³Rivas, *supra* note 106.

¹²⁴Sylvia R. Lazos Vargas, "Latina/o-ization" of the Midwest: *Combio De Colores (Change of Colors) as Agromaquilas Expand Into the Heartland*, 13 LA RAZA L.J. 343 (2002). This article addresses issues, including health care issues, that have arisen as a result of a large influx of Hispanic immigrants moving into areas of the rural Midwest.

¹²⁵*Id.*

where agriculture is more prominent.¹²⁶ In Missouri, most rural areas are experiencing a higher growth rate in their Latino populations compared to urban areas of the state.¹²⁷ The reason for the rapid growth in these areas is the amount of work available in agricultural activities and meatpacking jobs.¹²⁸

There is evidence that a significant proportion of the new immigrants moving to these rural agricultural areas have limited English proficiency.¹²⁹ About seventy percent of the immigrants in Southwest Missouri have reported having difficulty with English.¹³⁰ A study of Latino immigrants in rural areas found that “as many as three-quarters of Latinas have trouble with English.”¹³¹ Many of these immigrants come from Mexico with limited English skills and bring small children with them, who have no ability to speak English.¹³²

It is physicians in rural areas who receive the lowest payments from Medicaid and Medicare. Greater enforcement of existing guidelines will not be successful because physicians will not be able to afford the new technologies or the costs of translators for an increasing number of LEP patients. Physicians may be forced to move to larger, more urban areas and leave these rural areas, many of which are already classified as being “underserved,” in order to receive higher Medicaid and Medicare payments, and to have more access to people with private insurance. These physicians would be more likely to stay if they were reimbursed more for seeing Medicaid and Medicare patients, including the cost for providing medical translators for LEP patients.

C. Difficulties Successfully Suing for Disparate Impact in Medical Cases

Past cases suggest that Title VI health care cases were neither particularly common nor particularly successful.¹³³ The limited number of LEP discrimination cases that have gone to federal courts would suggest that plaintiffs were not successful in winning these cases even when there was a private right to sue and there is nothing to suggest that these cases would be success in providing more translators if the right was returned.¹³⁴ The lack of history of successful cases

¹²⁶*Id.*

¹²⁷*Id.* at 346.

¹²⁸*Id.*

¹²⁹*Id.* at 358.

¹³⁰*Id.* at 358-59.

¹³¹Lourdes Gouveia & Donald D. Stull, *Latino Immigrants, Meatpacking, and Rural Communities: A Case Study of Lexington, Nebraska, Research Report No. 26*, JULIAN SAMORA RESEARCH INSTITUTE, MICHIGAN STATE UNIVERSITY (Aug. 1997).

¹³²Lazos Vargas, *supra* note 124, at 351.

¹³³Rosenbaum & Teitelbaum, *supra* note 13, at 226.

¹³⁴An extensive search for cases has only produced one federal case where plaintiffs have sued privately under Title VI. This case was *Aghazadeh v. Maine Medical Center*, 1999 WL 33117182, No. 98-421-P-C (June 8, 1999 D. Me.). In this decision the court denied the defendant’s motion to dismiss the plaintiff’s complaint asking for putative damages they incurred from being denied a medical translator at the center. The court only held that there was a sufficient enough claim for the Plaintiffs to continue with the case. The court held that a

suggests that a private right to sue is not the best tool in ultimately getting more qualified medical translators in doctor's offices, and more concentration should be placed on programs that already have been shown to be successful.

The result of more litigation would most likely mean that even more physicians would stop seeing Medicaid or Medicare patients or be run out of business. Some of these physicians are already struggling to keep their doors open with the current fee structure, and could not afford the high costs of litigation. If physicians opt out of accepting Medicaid and Medicare patients, patients affected by this action would not have any recourse under Title VI even though the decision would disproportionately impact minorities.¹³⁵ Because Medicaid and Medicare pay rates far below market rates, the need to flee markets or stop accepting patients covered under these programs can be easily justified by physicians.¹³⁶ The cost of litigation, if LEP patients were allowed to sue in private actions in Title VI, would drive even more physicians out of participating in government programs, ultimately doing more harm than good.¹³⁷

Even if the right to private litigation were granted to immigrants, there are still a lot of barriers that would prohibit LEP plaintiffs from filing suit. Immigrants who are LEP might not seek litigation to enforce their rights because of ignorance about existing laws, or a fear of being a burden. This is evidenced by the number of immigrants who are reluctant to apply for federal aid for health care, like Medicaid, for fear of being a "public charge."¹³⁸ There is also a fear that applying for services could reveal their undocumented status to authorities.¹³⁹ It is doubtful that these immigrants would pursue legal rights via Title VI for language assistance for the very same reasons. Alternative solutions to helping LEP patients receive translators, besides a private right to sue, would be more inclusive because currently not all physicians are subject to the Department of Justice guidelines mandating these translators, and even if LEP patients had standing to sue, they may not have the resources or may not desire to bring an action.

person's primary language was close enough to their national origin so that discrimination based on the protected category of national origin could have occurred, and that the plaintiff's did not have to assert a claim of intentional discrimination in order to proceed with his/her private action. The latter decision was overturned by the Supreme Court's controversial decision in *Alexander v. Sandoval*, 532 U.S. 275 (2001). After the plaintiffs in *Aghazadeh* survived the defendant's motion to dismiss, the case was dismissed after the defendant reached a settlement agreement with the Office of Civil Rights.

¹³⁵Rosenbaum & Teitelbaum, *supra* note 13, at 228.

¹³⁶*Id.* at 229.

¹³⁷See Keers-Sanchez, *supra* note 11, at 573. Over two-thirds of physician offices are considered small businesses, and the loss of revenues that exceed income received cannot be easily maintained by small businesses. The effect would mean that these offices may be forced to close if litigation of cases, along with the costs of providing interpreters out of pocket, is too high.

¹³⁸Mee Moua, Fernando A. Guerra, Jill D. Moore, & Ronald O. Valdiserri, *Immigrant Health: Legal Tools/Legal Barriers*, 30 J.L. MED. & ETHICS 189, 192-93 (2002). This article discusses two federal laws that have had major implications for immigrants, especially health issues affecting Mexican immigrant communities.

¹³⁹*Id.*

D. Current Remedies Available for Disparate Impact Medical Cases

Despite what some critics of the Court's holding in *Sandavol* suggest, the Court did not take away a person's ability to seek assistance when a medical practice had a disparate impact on them because of their inability to speak English. These plaintiffs can file a complaint with the Department of Justice, which then has the duty to investigate. The opinion in *Sandoval* specifically holds that the Department of Justice can enforce its own policies against disparate impact practices.¹⁴⁰ First, the agency investigates to determine whether or not a program receiving federal assistance has a practice that has a disparate impact on the protected class and seeks voluntary compliance from the agency if there is such a finding.¹⁴¹ The Department of Justice will then enforce the policy by cutting off federal funds to the particular program or by some other lawful means.¹⁴²

In fact, the Department of Justice was successful in settling cases of disparate impact brought under Title VI, even when a private remedy was allowed. For example, the Advocates for Basic Legal Equality (ABLE) reached a settlement with Ohio, through the Department of Justice, that provided language assistance at its public health centers even though the plaintiffs sued privately.¹⁴³ The Department of Justice can still be used to get help for LEP patients without the threat of litigation via voluntary compliance and other measures.

Instead of suggesting that the government and non-profit organizations spend more time and resources on gaining the private right to enforce Title VI guidelines, LEP patient supporters would make more strides by using the Department of Justice services already provided and giving more support to programs that have already proven to be successful in providing qualified medical translators to LEP patients.

Greater enforcement of Health and Human Services guidelines would mean that there would be even fewer physicians available in underserved areas to treat Medicaid and Medicare patients, or any patients for that matter if the physicians are forced to move to more urban areas to sustain their practice.¹⁴⁴ Physicians in these areas are already struggling to keep their doors open with the paltry Medicaid and Medicare reimbursements, by bootstrapping the high cost of translation services to these government services via the spending clause fewer physicians will be able to afford practicing in these areas. Because more LEP patients are moving into rural areas, the problem of finding medical translators will only get worse.

VI. RECOMMENDATIONS

More federal money needs to be spent on three areas where there is already proof of methods that provide assistance to LEP patients in rural areas. These methods include the following: 1) increased affirmative action measures in the health care field; 2) increased Medicaid and Medicare payments to physicians in rural areas; and 3) increased government supported non-profit organizations.

¹⁴⁰Alexander v. Sandoval, 532 U.S. 275, 289 (2001).

¹⁴¹*Id.*

¹⁴²*Id.*

¹⁴³Plantiko, *supra* note 13, at 249.

¹⁴⁴Peterson, *supra* note 12, at 1441.

A. Reimburse Physicians for Medical Translators

Instead of pushing the government to spend more money enforcing existing guidelines, advocates for LEP patients should push the government to reimburse physicians for translation services or reimburse medical translators directly and subject them to a similar fee schedule as the one currently used for Medicaid and Medicare.

One of the most logical, but surprisingly overlooked, solutions is to have Medicaid and Medicare and private insurance companies reimburse physicians for using medical translators. For example, the Habloamos Juntos organization spent part of an 18.5 million dollar fund to investigate reasons for the limited number of medical interpreters being used in Los Angeles.¹⁴⁵ The survey results found that “physicians often complain about the cost of free-lance interpreters and insist that the government or insurance companies should pay.”¹⁴⁶ Medicare’s Practicing Physicians Advisory Council, at its recent meeting, expressed this same sentiment in a report.¹⁴⁷ The adversary committee felt that when medical interpretation is necessary, the interpreter should bill Medicare, Medicaid, or private insurance, and not the physician.¹⁴⁸

The physicians’ request is not unreasonable because the rates of private translators can be very high, especially compared to the reimbursement rates that physicians receive from the Medicaid and Medicare programs (both of these programs compensate at about sixty percent of the market rate).¹⁴⁹ At the recent Practicing Physicians Advisory Council meeting, an attendee recounted a story of a physician who was reimbursed thirty-seven dollars by Medicaid for treating a LEP patient and was then charged seventy dollars for the cost of the interpreter.¹⁵⁰ If you take into account that physicians are already struggling to break even with Medicaid reimbursement fee schedules, the amount charged for the interpreter seems even more outrageous.¹⁵¹

More private and public money should go towards directly reimbursing medical translators for services they provide, instead of making physicians pay out of their own pockets. The federal government offers matching programs to states to reimburse physicians for medical interpreters, but these programs are not effective

¹⁴⁵Neil Parikh, *The Language Barrier/An Unbridged Communication Gulf Keeps Immigrants From Getting Good Health Care*, THE ORANGE COUNTY REGISTER, Dec. 21, 2003, at A1.

¹⁴⁶*Id.*

¹⁴⁷Jennifer Silverman, *Interpreters Should Bill Insurers, Not Physicians: Medicare’s PPAC Recommends*, OB. GYN. NEWS, Nov. 15, 2003, at 30.

¹⁴⁸*Id.*

¹⁴⁹Andrew Kramer, *Declining Medicaid Payments Help Create Doctor Shortage in Rural Areas*, ASSOCIATED PRESS NEWSWIRE, Sept. 25, 2003, at 16: 19: 41.

¹⁵⁰Silverman, *supra* note 147.

¹⁵¹Keers-Sanchez, *supra* note 11, at 573. On average, Medicaid and Medicare reimburs physicians between thirty to fifty dollars (\$30-\$50) for visits, while the cost for medical translators can be anywhere from thirty dollars (\$30) to hundreds of dollars.

because of a low participation rate.¹⁵² States can obtain federal matching funds to apply for translation, but they must pay out their Medicaid dollars first. Unfortunately, only eight states have taken advantage of this program.¹⁵³ These programs are insufficient standing alone because with current state deficits, it does not seem likely that any other states will participate in the program.¹⁵⁴ More money needs to come from other private institutions, like insurance companies, to really make a difference.

Another suggestion would be to raise Medicaid and Medicare reimbursement rates for physicians living in rural areas to make changes in disparate impact practices, like translation services, seem more lucrative. In states like Oregon, physicians' practices are closing at a much greater rate in some rural areas than offices in urban areas within the same state, due in part to low Medicare and Medicaid reimbursements.¹⁵⁵ According to the Associated Press Newswires, "lower Medicaid and Medicare rates hurt country doctors more than urban and suburban doctors, because the percentage of public health recipients is greater in rural areas."¹⁵⁶ These closures will also have a greater impact on LEP patients because of the amount of LEP persons moving to rural areas in America, especially Latinos.¹⁵⁷

There is already a push in Congress to provide assistance with the health care struggles that providers are experiencing in rural, underserved areas.¹⁵⁸ The House has proposed a five percent (5%) bonus for physicians who are practicing in rural areas with a lot of Medicaid patients.¹⁵⁹ This bonus would be a good start in keeping physicians in these areas, and providing more money to spend on language assistance for LEP patients.

B. Increase Spending for Non-profit Organizations that Assist LEP Patients

The government could also successfully help more LEP patients in rural areas by funding organizations that are proven to help all LEP patients, not just those on Medicare or Medicaid. Many immigrants turn to non-profit agencies to get translators to help with medical appointments.¹⁶⁰ When Wilma Escalante, an immigrant with limited English proficiency, could not get the assistance she wanted from medical clinics for cosmetic treatment for burns, she turned to Latino Health

¹⁵²See Keers-Sanchez, *supra* note 11, at 573.

¹⁵³*Id.*

¹⁵⁴*Id.*

¹⁵⁵Kramer, *supra* note 149. In rural areas, such as Eastern Oregon, nearly ten percent (10%) of physicians were closing their offices because of the high costs of conducting business, according to a survey by the Oregon Medical Association conducted in Summer 2003.

¹⁵⁶*Id.*

¹⁵⁷See Lazos Vargas, *supra* note 124, at 343.

¹⁵⁸Brandert, *supra* note 115.

¹⁵⁹*Id.*

¹⁶⁰Parikh, *supra* note 145.

Access, advocacy and educational group.¹⁶¹ The group was able to call the clinic and set up the appointment for her when bilingual staff would be available to assist.¹⁶² Instead of providing funds to promote greater enforcement of Health and Human Guidelines, more money should be given to non-profit agencies that can provide what is really needed: translation and medical services

Free clinics and non-profit agencies have been successful in assisting immigrants' access to medical care in communities where there has been a great influx of immigrants.¹⁶³ The city of Goshen, Indiana has two clinics that assist with medical needs for immigrants, and most of their patients are Hispanic.¹⁶⁴ Currently, the clinics are partly supported by small fees paid by patients and donations from area churches that, like the members of Goshen's St. John Catholic Church, saw the need for such services in 1999.¹⁶⁵ If more funding were provided to clinic, the clinics could see more than the twenty to twenty-five patients they are currently seeing during the week.¹⁶⁶

Rural towns in Missouri also rely on free clinics to provide health care to immigrants; many of whom are Hispanic and have been recruited to work in meatpacking industry.¹⁶⁷ According to the director of the free clinic in Jasper County, Missouri, about seventy-five percent of the patients are Hispanic immigrants and previously were not receiving any type of health care.¹⁶⁸ The director said that "the primary reason Hispanic immigrants failed to seek health care was the lack of trust in other health care facilities;" the free clinic has been able to establish this trust since opening its doors three years ago.¹⁶⁹ The clinic is facing hard times because of the shortfall of state and federal support, and if the clinic closes the recent immigrants may, once again, stop seeking medical assistance.

Instead of spending more money to enforce existing policies and advocating a private right to sue for disparate treatment, LEP patients in rural parts of America would be better off if these funds were used to support non-profit translation services and free clinics.

¹⁶¹*Id.*

¹⁶²*Id.*

¹⁶³Rivas, *supra* note 106. The free clinic in Carthage, Missouri has been successful in helping new Hispanic residents, who were drawn to the rural town for meatpacking jobs, get medical care. The article also says that medical facilities in small rural towns have also relied on volunteers for medical translators.

¹⁶⁴Larry Ford, *A Tale Of Two Clinics; Elkhart County's Uninsured Find Health-Care Havens*, SOUTH BEND TRIBUNE, Nov. 16, 2003, at 1D.

¹⁶⁵*Id.*

¹⁶⁶*Id.*

¹⁶⁷Rivas, *supra* note 106.

¹⁶⁸*Id.*

¹⁶⁹*Id.*

C. Affirmative Action

Affirmative action programs need to be designed to get more minorities, especially Hispanic minorities who are bilingual, into the practice of medicine. In most cases, minorities who go to medical school will return to their own communities to practice upon graduation.¹⁷⁰ The benefit of increasing bilingual applicants to medical schools is two fold: 1) the physicians would be able to communicate directly with the patients, and 2) the physicians would be knowledgeable about the ways the traditions and customs of a culture would make an impact on medical care.

In a recent Supreme Court decision, the majority held that a state had a compelling interest in creating affirmative action programs for higher education and that these programs did not violate the Equal Protection Clause of the Fourteenth Amendment.¹⁷¹ More money needs to be spent to attract minority students, especially Hispanic students, to receive an education in the medical field where they are currently underrepresented.¹⁷² The amount of Hispanic physicians in the work force compared to the amount of Hispanics in the American population is staggering. In 1999, Hispanics amounted to approximately twelve percent of the U.S. population, but only three and a half percent of physicians.¹⁷³ Although there have not been any specific studies, other national groups, who are more likely to be bilingual, are underrepresented in medical fields as well.¹⁷⁴

As a companion to affirmative action programs, the government should also provide financing to organizations that help finance programs designed to get minority students interested in the medical field at the elementary, high school, and college levels.¹⁷⁵ Programs like the Department of Health and Human Services' Health Careers Opportunity Program (HCOP) and Centers of Excellence and the Minority Medical Education Program (MMEP) help to place more minority students in the pipeline for receiving medical degrees, which in turn supports the number of minority doctors in communities with LEP patients.¹⁷⁶

¹⁷⁰Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 ANN. HEALTH L. 121, 129 (2003). These studies show that "minority doctors open practices in minority neighborhoods in far greater numbers (nearly three-to-one) than do whites." Studies came from the following sources: John Zicconi, *What Color Should Medicine Be?*, 12 *Unique Opportunities*, THE PHYSICIAN'S RES. 26, 32 (2002); Vera B. Thurmond & Darrell G. Kirch, *Impact of Minority Physicians on Health Care*, 91 S. MED. J. 1009, 1010 (1998).

¹⁷¹*Grutter v. Bollinger*, 123 S.Ct. 2325 (2003).

¹⁷²*Id.* at 131; *Minority Graduates of U.S. Medical Schools: Trends, 1950-1998*, ASS'N OF AM. MED. COLL. REPORT 14 (2000).

¹⁷³Jordan J. Cohen, Barbara A. Gabriel, & Charles Terrell, *The Case For Diversity in the Health Care Workforce; Interventions to Improve The Racial and Ethnic Diversity of the U.S Medical Workforce Should Begin Well Before Medical School*, HEALTH AFFAIRS, (Sept.-Oct., 2002).

¹⁷⁴*Id.*

¹⁷⁵*Id.*

¹⁷⁶*Id.*

The government should be encouraged to spend more money on encouraging bilingual students to enter into the medical field, especially underrepresented minorities, like Hispanics, and less on trying to enforce private rights of LEP patients against physicians in rural areas.

VII. CONCLUSION

It does not make sense to spend greater money trying to enforce stipulations in the spending clause when physicians in rural areas are already losing money on government sponsored programs like Medicaid and Medicare. Instead, political pressure should be used to raise Medicaid and Medicare payments to private physicians in underserved areas, and to encourage states to provide matching funds to provide these physicians with funds for translators. Also, more government aid should be provided to programs that are already successful in assisting LEP patients, non-profit community centers, and programs that support affirmative action initiatives designed to get more bilingual physicians practicing in these underserved areas.

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