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REBALANCING HEALTHCARE INEQUITIES: LANGUAGE SERVICE REIMBURSEMENT MAY ENSURE MEANINGFUL ACCESS TO CARE FOR LEP PATIENTS

Siddharth Khanijou *

INTRODUCTION

The demographic landscape of the United States has changed dramatically over the last thirty years. Today, more than 34 million Americans are foreign born, and nearly 50 million people speak a language¹ other than English at home.² In eight states, the percentage of persons that speak a different language at home is significantly greater than the national average – 39.5 percent in California, 36.5 percent in New Mexico, 31 percent in Texas, and over 23 percent in Arizona, Hawaii, Nevada, New Jersey, and New York.³ In fact, in Los Angeles County alone, where 31 percent of residents are immigrants, over 80 different languages are spoken.⁴ Although immigration is generally

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¹ 2004 American Community Survey Data Profile Highlights, <http://factfinder.census.gov> (follow “Fact Sheet” hyperlink, follow “2004” hyperlink) [hereinafter 2004 Community Survey Data]. Over 300 different languages are spoken in the United States; excluding English, the 20 most commonly spoken are: Spanish, French, German, Italian, Chinese, Tagalog, Polish, Korean, Vietnamese, Portuguese, Japanese, Greek, Arabic, Hindi, Russian, Yiddish, Thai, Persian, French Creole, and Armenian. Office of Management and Budget (OMB), *Report to Congress, Assessments of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency* (March 2002), available at <http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf>.

² This statistic represents a 191 percent increase from foreign born Americans in 1970. Nearly 19 percent of the U.S. population speaks a language other than English at home. See 2004 Community Survey Data, *supra* note 1; Campbell Gibson & Emily Lennon, *Historical Census Statistics on the Born-Foreign Born Population of the United States: 1850 to 1990* (Feb. 1999), available at <http://www.census.gov/population/www/documentation/twps0029/twps0029.html> (last visited Dec. 7, 2005).

³ The Kaiser Commission on Medicaid and the Uninsured, *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities* (August 2003), available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22093>.

⁴ *Id.*

confined to urban areas, census data indicates an increasing diversity beyond the borders of traditionally urban jurisdictions.⁵ Current estimates indicate that 11 to 21 million Americans are not proficient in English, and this number is certain to increase based on current rates of immigration.⁶

Communication is the most fundamental element in the physician-patient relationship. Accurate communication is critical to ensure the proper exchange of information, to obtain informed consent to treat patients, and to prevent breaches in patient-provider confidentiality.⁷ The inability of limited English proficiency (LEP) patients to communicate with their healthcare providers can have negative effects on access to services and quality of care, particularly when trained interpreters are unavailable.⁸ “Language barriers may affect the delivery of adequate care through poor information exchange, loss of important cultural information, misunderstanding of physician instructions, poorly shared decision-making and ethical compromises, such as difficulty obtaining informed consent.”⁹ In addition, without appropriate translation services, racial and ethnic minority patients’ with low English reading proficiency may be disproportionately and negatively affected since they may be unable to comprehend written materials gathered from healthcare providers or social service agencies.¹⁰ Thus, language barriers are reflected in how LEP patients perceive their healthcare encounter and affect variables such as follow-up compliance, adherence with medication regimes, appointment attendance, and satisfaction with services.¹¹

Unfortunately, many providers are unaware of the existence of language barriers and the healthcare disparities that have resulted based

⁵ In Georgia, North Carolina, Nevada, Arkansas, Nebraska, and Utah, the percentage of the limited English proficiency (LEP) population has increased 243%, 243%, 234%, 170%, 160%, and 159%, respectively between 1990-2000. NATIONAL HEALTH LAW PROGRAM, LANGUAGE SERVICES ACTION KIT 35, *available at* http://www.cmwf.org/usr_doc/LEP_actionkit_reprint_0204.pdf. *See infra* n.6.

⁶ *Id.* at 1. Eleven million people, or 4.2% of the population, identified themselves as speaking English “not well” or “not at all,” and 21 million, or 8.1%, speak English less than “very well.” *See id.*

⁷ *Id.* at 33.

⁸ Allison Keers-Sanchez, *Mandatory Provision of Foreign Language Interpreters in Health Care Services*, 24 J. LEGAL MED. 557, 557.

⁹ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Barriers in Healthcare* 191 (Smedley et al. eds., 2002). [hereinafter IOM].

¹⁰ *Id.*

¹¹ *Id.*

on factors such as fluency in English or racial and ethnic background.¹² To help remedy the communication problems and the disparate care received by LEP patients, a number of state and federal laws and policies require providers that service patients enrolled in federally funded healthcare programs¹³ to ensure meaningful access to care for individuals with low English proficiency regardless of the providers' dependence on, or the extent of, funding they receive.¹⁴ But, since health care providers receiving federal funds must provide for interpreter services to be available to *all* LEP patients, not just Medicaid and State Children's Health Insurance Program (SCHIP) enrollees, a gap exists between existing federal funding dedicated to language services and the patient population in need for such services.¹⁵ This gap, along with a current scheme that provides negligible, if any, federal reimbursement for supplied language services, has made it cost ineffective to treat LEP patients. As a result, many physicians have withdrawn participation in Medicaid programs.¹⁶ In addition, despite the ubiquity of public funds in the healthcare industry, Title VI of the Civil Rights Act has not traditionally applied to doctors that only receive federal payments through Medicare Part B.¹⁷ Given that a potentially huge group of physicians are excluded from Title VI compliance, proponents for Title VI reform are quick to blame physicians for recent reports that document deep and pervasive disparities in the health and healthcare received by racial and ethnic minority populations.¹⁸ These reformists argue that the exclusion of

¹² See Kaiser Family Foundation, *National Survey of Physicians Part I: Doctors on Disparities in Medical Care, Highlights and Charts 3-4* (March 2002), available at www.kff.org/minorityhealth/20020321a-index.cfm. A majority of doctors believe disparities in how people are treated within the healthcare system "rarely" or "never" occur based on factors including fluency in English or racial and ethnic background.
Id.

¹³ Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) are programs that rely on federal funds.

¹⁴ NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 34.

¹⁵ *Id.* at 20.

¹⁶ See Brandy Glasser & Brian A. Liang, *Hearing Without Understanding: A Proposal to Modify Federal Translation Guidelines to Improve Healthcare for Citizens with Limited English Proficiency*, 35 J. HEALTH LAW 467, 476 (2002).

¹⁷ See Wayne Guglielmo, *The Translator Mandate Gets Easier: In Response to Criticism from Doctors, the Government has Revised Guidelines for Dealing with Non-English-Speaking Patients*, 81 MEDICAL ECONOMICS 72, 75 (2004).

¹⁸ Studies included in the IOM report indicate that racial and ethnic minorities experience disparate treatment and have higher rates of morbidity across many different disease areas, such as cardiovascular disease, cerebrovascular disease, HIV/AIDS, cancer, infant mortality, substance abuse, hypertension, diabetes,

physicians as recipients of federal funds is a legal fiction¹⁹ and that historical analysis of the development of the definition of “place of public accommodation” in the civil rights context reveals federal authority to regulate private enterprises.²⁰ However, I submit that their focus is misplaced. Blame should be laid, not on physicians, but on the failure of the system to make it economically and logistically feasible for physicians to provide high quality healthcare to all people, regardless of their English proficiency. Communication is the most important diagnostic tool available to physicians and, in general, physicians agree that communication with LEP persons can be improved.²¹ The debate centers, however, on who should be responsible for paying for interpretation services. A language access mandate would unfairly place physicians in an untenable position – either submit to financial strain by paying the cost of interpretation or risk administrative sanctions and potential liability in tort for language discrimination.²² Although the development of managed care has spurred novel and innovative ways to reduce the costs of health care, a

tuberculosis, and mental illness. See IOM, *supra* note 9, 5, 35, n.9. Many of these differences remain even after controlling for socioeconomic position and access-related factors. *Id.* at 5. Compared to their white counterparts, racial and ethnic minorities in the United States are less likely to receive appropriate preventative care, organ and tissue transplants, and aggressive treatment for end-stage renal disease. See AMA Report 5 of the Council on Scientific Affairs (2000), <http://www.ama-assn.org/ama/pub/article/print/2036-7205>. In fact, the disparity in average life expectancy between African Americans and whites has increased since 1960; a trend that suggests that the healthcare gap is not simply static, but may be increasing. IOM, *supra* note 9, at 35. However, the IOM admits that the health care disparity may be a function of differences in: cultural attitudes toward health, treatment preferences following informed consent, education, literacy or ability to understand treatment options, lifestyle choices, social and environmental risk factors, pharmacogenomic response to drug therapy, pathophysiology or susceptibility to certain diseases, and distrust; all of which were not controlled in studies. See generally IOM, *supra* note 9. Likewise, many aspects of the healthcare system exert effects on patient care that disproportionately affect minorities including high minority enrollment in Medicaid and “lower end” affordable-but-limited health plans, inadequate translation services, geographic unavailability of healthcare institutions, provider discretion in appropriate treatment options, and time pressures experienced by health professional also factor into the disparities equation.

¹⁹ Gordon Bonnyman, *Symposium: Dynamic Conservatism and the Demise of Title VI*, 48 ST. LOUIS L.J. 61, 67.

²⁰ Joel Teitelbaum & Sara Rosenbaum, *Medical Care as a Public Accommodation: Moving the Discussion to Race*, 29 AM. J. L. & MED. 381, 383.

²¹ Elizabeth Beckley, *Speak in Tongues: Cultural Respect Can be Shown Through Use of Language*, MODERN PHYSICIAN 22 (January 1, 2002).

²² Keers-Sanchez, *supra* note 8, at 558.

mandate that requires medical providers to absorb the costs of interpreters unfairly shifts the burden.

This commentary suggests that the healthcare disparity experienced by patients with low English proficiency can be reduced by developing easy-to-access, and appropriately reimbursed, language services. Part I provides an overview of the legal landscape that protects LEP patients against language discrimination. Part II discusses avenues of liability for physicians that treat LEP patients. Part III discusses the problems created by language barriers and interpreter services. Finally, Part IV proposes a national telephone translation service and a public reimbursement scheme that reflects the cost of the service.

PART I: FEDERAL PROHIBITION OF LANGUAGE DISCRIMINATION

A. The Civil Rights Act of 1964

No legislative enactment specifically protects against language discrimination. However, many courts²³ and governmental agencies²⁴ have begun to interpret the Civil Rights Act of 1964 as protecting

²³ See, e.g., *Yniguez v. Arizonans*, 69 F.3d 920 (9th Cir. 1995). In *Yniguez v. Arizonans for Official English*, the Court stated: “Since language is a close and meaningful proxy for national origin, restriction on the use of languages may mask discrimination against specific national origin groups or, more generally, conceal nativist sentiment.” *Yniguez*, 69 F.3d at 947-48.

²⁴ The Department of Justice states that “While there is not always a direct relationship between an individual’s language and national origin, often language does serve as an identifier of national origin.” See also Enforcement of Title VI of the Civil Rights Act of 1964 – National Origin Discrimination against Persons with Limited English Proficiency, 65 FED. REG. 50,123 (Aug 16, 2000) (where the purpose of the DHHS Policy guidance was to reiterate DHHS’ “longstanding position that in order to avoid discrimination against LEP persons on grounds of national origin, health and social service providers must take adequate steps to ensure that such person receive language assistance necessary to afford them meaningful access to services.”). However, many critics argue that because neither the Congress nor the courts had interpreted Title VI to prohibit language discrimination, the DHHS Policy Guidance was not an interpretation of existing law, but rather new law created without the formal Notice of Proposed Rulemaking required by the Administrative Procedures Act (APA). Mona Peterson, *The Unauthorized Protection of Language Under Title VI*, 85 MINN. L. REV. 1437, 1465 (2001). The use of commanding language, such as “shall,” “must,” and “required,” indicates that the DHHS Policy Guidance is binding on federal fund recipients, not permissive. *Id.* at 1464. These critics argue that an interpretation of Title VI that mandates language assistance on federal recipients violates principles of federal law. See *id.*

individuals from language discrimination based on the concern that language restrictions might veil discrimination based on race and national origin.²⁵ With recent reports chronicling health disparities and the continued inequities in our healthcare system, Title VI of the Civil Rights Act of 1964 has become an important tool to protect and advance language rights in the context of government programs. Although originally designed to combat discrimination on the basis of race and national origin, the introduction of Title VI has had a ripple effect and benefited women, the disabled, and many other groups.²⁶ It remains the blueprint upon which many other anti-discrimination statutes, such as the Americans with Disabilities Act and the Rehabilitation Act, were based.²⁷

1. Limits to the Reach of Title VI

Section 601 of Title VI of the Civil Rights Act 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.”²⁸ The early history of the Act demonstrated the potency of using federal funding as a means to cure inequality as Title VI regulations outlawed many practices of administering federal programs that were discriminatory in effect (*de facto*) without requiring proof of discriminatory intent.²⁹ Thus, the Civil Rights Act was aimed at prohibiting not only intentional discrimination (clearly prohibited by § 601), but a more subtle form of discrimination, disparate impact (prohibited by § 602³⁰), as well.

The Act represented a watershed moment in U.S. civil rights policy; it was intended to remedy discrimination in areas including employment, housing, federally assisted programs and public

²⁵ 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, 245 (2002).

²⁶ *Id.*

²⁷ *Id.*

²⁸ 42 U.S.C. §2000d (2002).

²⁹ Bonnyman, *supra* note 19, at 71.

³⁰ Section 602 contains regulations implementing §601 of Title VI and integrate a prohibition against disparate impact discrimination. A recipient of federal funds may not “utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination, because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular race, color, or national origin. 45 C.F.R. §80.3(b)(2) (2003).

accommodations.³¹ Under the Act, the term “public accommodations” reaches “enterprises that sell their services to the general public and whose activities affect commerce.”³² Reflecting the common law concepts of public accommodation as understood in 1964, the Act specifically “reaches inns, hotels and motels, restaurant and food establishments, and places of exhibition and entertainment.”³³ However, the definition of place of “public accommodation” did not explicitly include medical care providers and facilities.³⁴ The Act applies *only* where there is evidence that the health provider or facility has received federal funds.³⁵ Still, the healthcare industry is greatly influenced by regulations tied to the receipt of federal funding since these funds account for almost one half of all money spent on healthcare. In 2002 alone, the United States spent \$1.6 trillion on health care; approximately 14.9 percent of the U.S. Gross Domestic Product.³⁶ Although private insurance covers a large portion of healthcare expenditures, federal funding makes up approximately 46 cents of each dollar spent on healthcare.³⁷ Hospitals, nursing homes, state Medicaid agencies, and welfare agencies, all of which receive some funding from government grant programs, are examples of covered entities.³⁸

2. Disintegration of the Private Right of Action

Prior to 2001, the strength of Title VI action came from the ability of Title VI plaintiffs to challenge facially neutral policies with a disparate impact.³⁹ In the landmark case of *Lau v. Nichols*, a unanimous Supreme Court in 1974 recognized a private right of action to protect against disparate impact discrimination.⁴⁰ This right allowed a private individual to bring a lawsuit to enforce regulations under Title VI. In *Lau*, students of Chinese ancestry brought a class action suit against the San Francisco Unified School District alleging that the school system’s facially neutral policy of not providing supplemental English language instruction violated Title VI because it had the effect of excluding non-

³¹ Teitelbaum, *supra* note 20, at 382.

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ Teitelbaum, *supra* note 20, at 382.

³⁶ See Cathy Cowan et al., *National Health Expenditures, 2002*, at 143 (2004), available at <http://www.cms.hhs.gov/review/04Summer/04Summerpg143.pdf>.

³⁷ *Id.* at 146.

³⁸ Keers-Sanchez, *supra* note 8, at 563.

³⁹ Plantiko, *supra* note 25, at 247.

⁴⁰ Keers-Sanchez, *supra* note 8, at 564.

English speaking students from the school's educational programs.⁴¹ The Court held that the school denied the students meaningful access to public education in violation of Title VI.⁴² The Court noted that "merely providing students with the same facilities, textbooks, teachers, and curriculum does not translate into equal treatment" since students unable to understand English cannot benefit from their educational opportunity.⁴³ This interpretation was consistent with the Department of Health, Education, and Welfare proscription of policies that have a discriminatory effect, even absent a purposeful design to discriminate, because they "substantially impair accomplishment of [a] program's objectives."⁴⁴ Thus, *Lau* required that federal funds recipients take reasonable steps to ensure that language barriers do not "exclude LEP persons from effective participation in its benefits and services."⁴⁵

Although *Lau* was decided in the context of meaningful access to education, the failure to provide language assistance in healthcare settings can be viewed as having a similar effect of excluding LEP speakers from essential medical services.⁴⁶ Both the Department of Justice (DOJ)⁴⁷ and the Department of Health and Human Services (DHHS) have adopted policy guidelines to improve access to medical services for persons with limited English proficiency to prevent and diminish national origin discrimination.⁴⁸ The DHHS, for example, has

⁴¹ See *Lau v Nichols*, 414 U.S. 563 (1974).

⁴² *Id.* at 568.

⁴³ Plantiko, *supra* note 25, at 247-48.

⁴⁴ *Id.* at 248.

⁴⁵ Keers-Sanchez, *supra* note 8, at 564.

⁴⁶ Plantiko, *supra* note 25, at 248.

⁴⁷ The DOJ suggests that recipients can ensure that LEP persons have meaningful access to their programs through an individualized assessment that balances the following four factors:

- (1) The Number or Proportion of LEP Persons Served or Encountered in the Eligible Service Population;
- (2) The Frequency with which LEP Individuals Come in Contact with the Program;
- (3) The Nature and Importance of the Program, Activity, Service Provided by the Program; and
- (4) The Resources Available to the Recipient and Costs

After a fact-specific analysis, the proper balance is achieved when LEP persons are able to access effective healthcare at a level comparable to English-speaking patients without an unnecessary or undue burden on health providers. See also *Improving Access to Services for People with Limited English Proficiency*, Exec. Order No. 13,166 (August 11, 2000). See generally 67 FED. REG. 41455 (June 18, 2002).

⁴⁸ See generally *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English*

suggested that health providers and organizations that receive federal funds can determine what reasonable steps should be taken to ensure that LEP persons have meaningful access to language services and compliance with Title VI by a four factor analysis that considers:

- (1) The Number or Proportion of LEP Individuals Eligible to be Served or Likely to be Encountered by the Program or Grantee;
- (2) The Frequency with which LEP Individuals Come in Contact with the Program;
- (3) The Nature and Importance of the Program, Activity, or Service Provided by the Program to People's Lives; and
- (4) The Resources Available to the Grantee/Recipient and Costs⁴⁹

These guidelines reiterate that Title VI regulations prohibit both intentional discriminatory policies and those that have a discriminatory effect.⁵⁰ The HHS guidance notes that the failure to provide language assistance for LEP individuals in the health and social service sector may delay or deny their access to essential services.⁵¹ Therefore, entities charged with the implementation of the Civil Rights Act have extended *Lau's* ruling to the medical environment and placed upon covered healthcare providers an affirmative duty to eliminate existing language barriers or face potential civil rights litigation.⁵²

However, the vitality behind the Civil Rights Act was all but gutted after the Supreme Court's controversial decision in *Alexander v. Sandoval* in 2002.⁵³ In *Sandoval*, plaintiffs brought suit against the

Proficient Persons, 67 FED. REG. 41,455; *see also* Title VI of the Civil Rights Act: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 65 FED. REG. 52,762 (August 30, 2000). The DHHS, as early as 1980, recognized that "because persons of limited English are disproportionately represented in certain national origin groups, the inability to communicate with persons of [LEP] has the effect of discriminating on the basis of national origin." Nondiscrimination on the Basis of Race, Color, or National Origin Under Programs Receiving Federal Assistance Through the Department of Health and Human Services, 45 FED. REG. 82,972 (Dec. 17, 1980).

⁴⁹ NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 9.

⁵⁰ Plantiko, *supra* note 25, at 248.

⁵¹ 65 FED. REG. 52,762, 52,763.

⁵² OCR guidelines mandate that physicians and other health care providers supply interpretation services if they accept reimbursement under Medicaid or SCHIP. Plantiko, *supra* note 25, at 246.

⁵³ Teitelbaum, *supra* note 20, at 393.

Director of State Public Safety of Alabama alleging national origin discrimination under Title VI because the state administers driver's license examinations in English only.⁵⁴ The Court held, however, that despite the proscription of disparate impact regulations under §602, a private party cannot bring suit to enjoin Alabama's policy under Title VI.⁵⁵ This effectively abolished 40 years of legal authority.⁵⁶ Although both the DHHS and the DOJ maintain that *Sandoval* has not invalidated Title VI disparate impact regulations,⁵⁷ the inability of a plaintiff to bring a private action to enforce disparate impact discrimination has severely crippled, if not eliminated, litigation as a Title VI regulatory mechanism.⁵⁸ Private rights of action remain in intentional or deliberate discrimination claims, but difficulties proving such discrimination have prevented successful claims.⁵⁹

3. The Office of Civil Rights: A Broken Compliance Mechanism

In light of the bar to private enforcement of *de facto* discrimination, *Sandoval* effectively anointed federal agencies as the sole enforcers of Title VI, insofar as allegations of disparate impact are concerned.⁶⁰ An LEP individual may file a complaint with the agency that dispenses federal funds within 180 days of the alleged discriminatory act.⁶¹ Under Title VI, the LEP person must identify the specific regulations violated by the act.⁶² Once a complaint is reported, the Office of Civil Rights (OCR) is required to investigate the alleged incident, evaluate whether the alleged act constitutes discrimination, inform the relevant parties of

⁵⁴ Plantiko, *supra* note 25, at 252.

⁵⁵ Keers-Sanchez, *supra* note 8, at 565.

⁵⁶ Teitelbaum, *supra* note 20, at 392-93.

⁵⁷ U.S. Department of Justice, *Memorandum for Heads of Departments and Agencies General Counsels and Civil Rights Directors* (Jan. 11, 2002), available at <http://www.usdoj.gov/crt/cor/lep/BoydJan112002.pdf> (The Assistant Attorney General stated that because *Sandoval* did not invalidate and Title VI regulations that proscribe conduct that has a disparate impact on covered groups – the types of regulations that form the basis for the part of Executive Order 13166 that applies to Federally assisted programs and activities – the Executive Order remains in force.

⁵⁸ Teitelbaum, *supra* note 20, at 393.

⁵⁹ See, e.g., *Steptoe v. Savings of America*, 800 F Supp. 1542, 1548 (1992) (where Court dismissed a black homeowners' Title VI claim that mortgage lender intentionally discriminated by sabotaged their chances of buying a home in a white neighborhood because of a failure of proof).

⁶⁰ Teitelbaum, *supra* note 20, at 393.

⁶¹ Peterson, *supra* note 24, at 1450-51.

⁶² *Id.*

its findings, and take disciplinary action where appropriate.⁶³ If the federal funds recipient fails to prove it provides meaningful access to services, OCR has a number of options to ensure the correction of a civil rights violation.⁶⁴ Initially, the OCR will work with the funds recipient and provide information on the provision of interpreters to seek voluntary compliance and improve access to services.⁶⁵ However, if the funds recipient fails to correct the deficiency, the OCR may refer the entity to the DOJ for injunctive relief or revoke federal funding after an administrative hearing.⁶⁶

Unfortunately, the OCR has historically suffered from inadequate funding and a shortage of administrative resources to effectively monitor and enforce compliance.⁶⁷ To enforce the prohibition of policies that are discriminatory in effect, statistic data must be collected and analyzed to reveal patterns of unintentional discrimination.⁶⁸ Although, the DOJ has recently promulgated rules that require federal agencies, such as the DHHS, to “provide for the collection of data and information...sufficient to permit effective enforcement of Title VI,”⁶⁹ lackluster enforcement makes it impossible to monitor compliance.⁷⁰ This has reduced administrative enforcement to all but a dead letter.

4. Private Physicians are Exempt from Title VI Compliance

In the same year *Sandoval* was decided, the Institute of Medicine reported widespread racial and ethnic disparities and continued inequity of the healthcare system.⁷¹ Without a means to ensure physician accountability, civil rights activists blamed the healthcare quality problem on “biased judgment and problematic patient care interaction” within the medical profession.⁷² Interestingly however, the various

⁶³ *Id.*

⁶⁴ Keers-Sanchez, *supra* note 8, at 565.

⁶⁵ 65 FED. REG. 52,771-72. OCR will focus its compliance review efforts primarily on larger recipient/covered entities such as hospitals, managed care organizations, state agencies, and social service organizations, that have a significant percentage of LEP persons eligible to be served by the covered entity’s program. *Id.*

⁶⁶ *Id.* at 52,772.

⁶⁷ Bonnyman, *supra* note 19, at 69.

⁶⁸ *Id.* at 70.

⁶⁹ 28 C.F.R. §42.406(a) (2003).

⁷⁰ Bonnyman, *supra* note 19, at 70.

⁷¹ See John McDonough et al, *A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities* vii (June 2004), available at http://www.cmwf.org/programs/minority/mcdonough_statepolicyagenda_746.pdf.

⁷² Teitelbaum, *supra* note 20, at 390.

supply-side⁷³ or demand-side⁷⁴ cost containment strategies employed by managed care organizations (MCOs) as competition strategies were never held responsible for poor quality of care;⁷⁵ neither were patient-level or system-level deficiencies brought about by the institutional dynamics of managed care.⁷⁶

Of course, the fact that many private physicians are exempt from Title VI compliance has not helped the profession's cause. Physicians are only bound by Title VI compliance if they choose to treat patients on Medicaid or receive other federal funds. However, physicians that treat Medicare patients are not covered entities since Medicare's payments to physicians, under Medicare Part B, does not constitute "federal financial assistance."⁷⁷ This position has led reformists to assert that efforts aimed to improve quality care are futile as long as physicians in private practices are beyond the scope of legal accountability.⁷⁸ Some advocate that application of Title VI to private physicians who accept Medicare would significantly impact healthcare quality by extending the law's reach to a significant segment of the healthcare industry.⁷⁹ Others assert that a physician exemption from Title VI is a legal fiction and any attempt to parse and disentangle revenue streams within the current healthcare system would be

⁷³ MCOs practice cost control by shifting the responsibility of controlling costs unto physicians. IOM, *supra* note 9, at 151. *Id.* ("Economic rewards for frugality or penalties for costly tests, treatments, and referrals have become common in contemporary clinical practice. The result has been increased reliance on the discretion of gatekeeping clinical caretakers to set limits and manage scarce resources). This discretion, however, may allow cognitive, affective, social, and cultural factors to influence clinical discretion in racially disparate ways. *Id.*

⁷⁴ Incentives to patients to constrain the use of services through high co-payments and poor access to services. *Id.* at 151. Unfortunately, minorities are disproportionately represented in "lower-end" healthcare plans that employ these incentives and are less likely to be seen by a private physician, or have a regular primary health provider. *Id.* at 151. IOM, *supra* note 9, at 154-55 ("Moreover, they are more likely to receive care in hospital clinics and other settings characterized by rapid staff turnover and lack of continuity of care providers. Under these circumstances, it is reasonable to assume that physician advocacy on behalf of patients will be less likely, either because the physician is less familiar with the patient... or because resource constraints such as capitation prevent physicians from meeting all patients' demands for services).

⁷⁵ *Id.* at 151.

⁷⁶ *Id.*

⁷⁷ IOM, *supra* note 9, at 158.

⁷⁸ Teitelbaum, *supra* note 20, at 390.

⁷⁹ IOM, *supra* note 9, at 158.

undermined by the legions of ways in which government revenues support the healthcare enterprise.⁸⁰

Regardless, the current state of the law categorically excludes many physicians from Title VI compliance. Any effort to guarantee equal, high-quality medical care as a fundamental right by classifying state-sanctioned private conduct as “state action” can only lead to additional litigation that would further compromise and denigrate quality care.

B. The Americans with Disabilities Act of 1990

The absence of an explicit inclusion of “healthcare providers” in the Civil Rights Act’s definition of places of public accommodation exempted many private physicians from Title VI compliance.⁸¹ However, with the enactment of the Americans with Disabilities Act (ADA) in 1990 came a seminal shift in public accommodation policy.⁸² The ADA expanded on principles established in §504 of the Rehabilitation act of 1973, and was intended to “provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”⁸³ It was acknowledged as the most extensive and important civil rights initiative since the Civil Rights Act of 1964 and was, in fact, premised on the 1964 legislation.⁸⁴ Most significant about the ADA from the healthcare perspective is its “vast expansion of the concept of place of public accommodation.”⁸⁵ Although regulations defining places of public accommodation under the ADA begin with the usual litany of travel related entities, it expands on those explicated in the Civil Rights Act to include professional and commercial enterprises such as “laundromat, dry-cleaner, bank, barbershop, beauty shop, travel service, shoe, repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy,

⁸⁰ Teitelbaum, *supra* note 20, at 392 (“[A] brief review of U.S. tax policy reveals several ways in which government policies favor a large and dynamic “private” health system: the exclusion of employer contributions from taxable income, favorable tax treatment for sheltered individual payments to medical providers through flexible spending accounts... [numerous] non-profit tax exemptions to scholarship and loan forgiveness programs, and favorable treatment of capital investments”).

⁸¹ Teitelbaum, *supra* note 20, at 386.

⁸² *Id.*

⁸³ 42 U.S.C. §12101(b)(1) (2000).

⁸⁴ Teitelbaum, *supra* note 20, at 386-87 (“[t]he reach of both laws extends to the private sector and Title III of the ADA, modeled after Title I of the Civil Rights Act, prohibits discrimination in places of public accommodation.”).

⁸⁵ Teitelbaum, *supra* note 20, at 387.

insurance office, professional office of a health care provider, hospital, or other service establishment.”⁸⁶ Consequently, the law conferred upon medical professions “a legal duty to serve otherwise qualified individuals with disabilities.”⁸⁷

In addition to extending the public accommodation theory, the ADA expanded discrimination beyond “an overt and deliberate effort to exclude.”⁸⁸ Public accommodation discrimination includes, in pertinent part:

(i) a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such [services];

(ii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such [services] or would result in undue burden.⁸⁹

Therefore, at least in the disability context, public accountability extends beyond receipt of direct federal funding.⁹⁰ In fact, although *Sandoval* abolished the private right of action under the Civil Rights Act, language discrimination cases based on disparate impact are encouraged under the ADA and typically brought by the hearing impaired.⁹¹

⁸⁶ 28 C.F.R. § 36.104.(c) (2002).

⁸⁷ Teitelbaum, *supra* note 20, at 387.

⁸⁸ *Id.* at 388.

⁸⁹ *Id.*

⁹⁰ Teitelbaum, *supra* note 20, at 389.

⁹¹ *See, e.g.,* U.S.A. v. York Obstetrics & Gynecology, 2000 U.S. Dist. LEXIS 12564 (2000) (where the court denied summary judgment and held that defendant was required to provide an interpreter during prenatal care even if Smith-McLaren agreed that one was not necessary); *see e.g.,* Negron v. Snoqualme Valley Hosp., 936 P. 2d 55 (1997) (denying summary judgment because the hospital could not explain why it failed to call an emergency number for an interpreter request or why it could not synchronize the visits of an interpreter with visits by attending doctors. The claim is

PART II: POTENTIAL CIVIL PENALTIES FOR FAILING TO PROVIDE LANGUAGE ASSISTANCE SERVICES

A fundamental tenet of law states that while physicians have no duty to provide care to patients (except perhaps in emergency situations within hospital settings), physicians who choose to offer lifesaving treatments that lead to a bad result may be liable in tort. Although federal law does not mandate that private physicians use interpreter services on patients with limited English proficiency, a failure to do so may result in tort liability. If physicians treat patients with whom they cannot effectively communicate, the potential exists for malpractice lawsuits due to improper medical care, lack of informed consent, or breach of duty to warn.⁹²

A. Improper Medical Care

Delayed, incorrect, or improper medical care may result when a physician cannot understand a patient due to language discordance.⁹³ Without the aid of an interpreter, some physicians may not order necessary diagnostic tests and may make incorrect diagnoses based on partial or incorrect information.⁹⁴ These misdiagnoses⁹⁵ may have serious health consequences for the patient and may lead to a medical malpractice suit against the physician.⁹⁶ Other physicians may rely on batteries of expensive and often unnecessary tests to fill the language gap in an effort to avoid liability.⁹⁷ Valuable time and resources are

not one of medical negligence, since the Hospital saved plaintiff's life, but of discrimination because they treated her without consent and differently based on her disability.)

⁹² Keers-Sanchez, *supra* note 8, at 558-59.

⁹³ See 65 FED. REG. 52,762.

⁹⁴ Keers-Sanchez, *supra* note 8, at 559.

⁹⁵ Latino experiences accessing healthcare illustrate the issues and dangers faced by LEP patients when they seek medical attention. In 1984, a patient was brought into a Florida emergency department accompanied by his mother and girlfriend, who told the physicians that he was "intoxicado" – which meant nauseous. The staff, who spoke no Spanish, treated the patient as if he was drunk or on drugs. Barbara Weiss, *Cultural Competence: Caring for Latino Patients*, MEDICAL ECONOMICS, Apr. 23, 2004, at 38. Two days later, still undiagnosed, he experienced respiratory arrest and was found to have multiple hematomas and brain stem compression which left him quadriplegic. *Id.* He sued the hospital, paramedics, and physicians, and was awarded a settlement that could eventually reach more than \$70 million. *Id.*

⁹⁶ Keers-Sanchez, *supra* note 8, at 559.

⁹⁷ *Id.*

wasted on these unwarranted tests simply because of failures to communicate.

B. Lack of Informed Consent

A physician who fails to provide interpreter services to LEP patients may also be liable for failing to obtain the patient's consent to proceed with treatment.⁹⁸ Informed consent requires the physician to disclose reasonable medical treatment information relating to benefits, potential complications, and costs such that patients may make educated decisions about their medical or surgical management. Oftentimes, issues of informed consent arise when a patient and physician are not able to effectively communicate with each other regarding personal preferences and vital health information.⁹⁹ In such instances, physicians who proceed with treatment without obtaining voluntary consent after adequate¹⁰⁰ disclosure, be may be liable for violating consent requirements.¹⁰¹

C. Breach of Duty to Warn

Under the Learned Intermediary Doctrine, "pharmaceutical companies fulfill their duty to warn customers by warning physicians of the known risks of prescription medications."¹⁰² Physicians are expected to relay this information to patients and warn them of potential risks after prescribing the appropriate type and dose of drug based on their medical expertise and individual clinical assessment.¹⁰³ A language barrier between physicians and patients that results in communication difficulties may result in serious consequences if physicians are unable to ensure that LEP patients understand the warnings or appreciate the risks of certain medications.¹⁰⁴ If physicians breach the duty to warn,

⁹⁸ *Id.* at 559-60.

⁹⁹ *See generally* 65 FED. REG. 52,762.

¹⁰⁰ Disclosure must be equivalent to what a reasonable medical practitioner in the same or similar community would have disclosed regarding the benefits and risks posed by the proposed procedure.

¹⁰¹ Keers-Sanchez, *supra* note 8, at 560 ("[i]n *Quintero v. Encarnacion*, a member of a Tarahumara Indian tribe, [whose primary language was Ramuri], charged a group of physicians with providing inadequate medical care resulting from their failure to provide interpreter services... The court held that the patient had a right to be informed of the nature and effects of medications prescribed to her").

¹⁰² *Id.* at 561.

¹⁰³ *Id.*

¹⁰⁴ A communication disconnect may lead to an incomplete patient history and assessment which could result in the prescription of contraindicated medication that is potentially life-threatening.

the prescribed treatment may be ineffective or harmful and patients may have recourse in tort.¹⁰⁵

PART III: CHALLENGES AND OBSTACLES TO THE USE OF QUALIFIED INTERPRETERS FACED BY HEALTHCARE PROVIDERS

With the inability of federal law to regulate the actions of private physicians, health plans have taken steps to hold physicians accountable for quality care. At the same time, the shift to a system of managed care has placed additional demands on physicians while cutting compensation for services they are required to provide. Proponents of mandatory language assistance argue that the exclusion of physicians as Title VI covered entities evidences a resurfacing of explicitly racist practices in an unequal healthcare system.¹⁰⁶ However, they seem to have turned a blind eye to the actions of numerous medical institutions that are endorsing the importance of cultural competency and health literacy.¹⁰⁷ Both the American Medical Association (AMA) and the Institute of Medicine have investigated “best practices” and distributed “speakers’ kits” to physician groups highlighting techniques to ensure culturally competent care.¹⁰⁸ They have also advocated for the hiring of bilingual staff, providing patient information in numerous languages, and training for physicians to ensure that LEP patients understand treatment regimens.¹⁰⁹ The fact

¹⁰⁵ Keers-Sanchez, *supra* note 8, at 561.

¹⁰⁶ See generally Bonnyman, *supra* note 19.

¹⁰⁷ Health literacy is a shared function between patients and those with whom they interact to obtain and understand health interaction. Health literacy is the ability to obtain, read, and understand, and use health information to make appropriate decisions about one’s medical care. It differs from general literacy because the reading and understanding occur in the context of healthcare. Persons with otherwise acceptable reading skills may find it difficult to understand the concepts and vocabulary used in health-related communications. UNDERSTANDING HEALTH LITERACY: IMPLICATIONS FOR MEDICINE AND PUBLIC HEALTH 17 (Joanne G. Schwartzberg et al. eds., AMA 2005).

¹⁰⁸ See AMERICAN MEDICAL ASSOCIATION, CULTURAL COMPETENCE COMPENDIUM xi (1999).

¹⁰⁹ DHHS, *Recommended Standards for Culturally and Linguistically Appropriate Health Care Services*, PUBLIC HEALTH REP 2000 (February 2000). These are part of the DHHS’ recommended standards for culturally and linguistically appropriate healthcare services (CLAS Standards). Other measures to ensure equal access to quality healthcare by diverse populations include: (1) promoting attitudes, behaviors, knowledge, and skills necessary for staff to respect diverse patients; (2) having a comprehensive management strategy to address culturally and linguistically

that physicians and medical organizations are continually evolving to accommodate the needs of an increasingly diverse patient population is a testament to the adaptability of the profession.

However, the provision that interpreter services be available to *all* LEP patients is currently not possible due to personnel resources and economic restraints.¹¹⁰ Most physicians understand the importance of effective communication and many have sought training to enhance the physician-patient dialogue and reduce impressions of paternalistic care.¹¹¹ Certain LEP persons cannot successfully communicate with healthcare providers without professional interpretation services.¹¹² But before advancing policy initiatives to address the needs of these patients, it is important to identify the difficulties and burdens physicians may face when offering competent language services.

A. The Expense of Medical Translation

The DHHS policy guidance places upon physicians the responsibility of hiring interpreters, ensuring their competence, and guaranteeing their availability when requested or needed.¹¹³ Although the DHHS claims to be mindful of cost as a legitimate consideration in identifying the reasonableness of particular language assistance measures, its guidelines (which necessitate some form of interpreter services) apply with equal force to major hospitals, health maintenance organizations (HMOs), public clinics, as well as the smallest medical practices.¹¹⁴ This imposes a serious financial burden on many federal funds recipients. The AMA reports that at least two-thirds of physicians practice solo or in small groups.¹¹⁵ Businesses, particularly small businesses, cannot be maintained when costs exceed revenues. Therefore, many physicians have stopped treating Medicaid patients

appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsibility for implementation; (3) utilizing formal mechanisms for community and consumer involvement in the design and execution of service delivery; (4) requiring and arranging ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery; and (5) ensure that bilingual staff can demonstrate bilingual proficiency and receive training regarding the ethics of interpreting. *Id.*

¹¹⁰ Robert Gilmore, *AMA Letter to Office of Management & Budget re: Access to Healthcare for Individuals with Limited English Proficiency* (Dec. 21, 2001), available at <http://www.ama-assn.org/ama/pub/print/articles/6073-5812.html>.

¹¹¹ See generally UNDERSTANDING HEALTH LITERACY, *supra* note 107.

¹¹² Keers-Sanchez, *supra* note 9, at 569.

¹¹³ See 67 FED. REG. 41455.

¹¹⁴ Glasser, *supra* note 16, at 475.

¹¹⁵ See Gilmore, *supra* note 110.

since the costs of providing an interpreter surpass reimbursement from government programs.¹¹⁶ The frustration that many physicians face because of the DHHS mandate is best summed up by the words of former AMA President Yank Coble, MD: "What is new is the sudden government intrusion in this area without any investigation of the impact or the degree of burden or cost."¹¹⁷ Ironically, because the government's mandate to supply language services is largely unfunded, it has created an access problem for the very people it was designed to aid.¹¹⁸ The Title VI goal of ensuring meaningful access to essential healthcare services cannot be achieved if facilities are forced to close, or quit accepting federal funding, because they cannot bear the cost of providing interpreters.

1. The Inadequacy of the Current Reimbursement Scheme

The annual cost for interpretation services across the healthcare industry is estimated at \$267.6 million.¹¹⁹ Medicare and Medicaid reimburse approximately \$30 to \$50 per visit to the healthcare provider.¹²⁰ However, the cost of translation services can greatly exceed that amount and may cost anywhere from \$30 to \$400 depending on the length of translation, whether the interpreter is medically certified, and the language that requires translation.¹²¹ While healthcare providers that receive federal funds must provide for meaningful language access to *all* patients, states are not obligated to reimburse providers for these expenses.¹²² Some federal funds are available for medical interpreter services, but individual providers cannot seek reimbursement unless their state implements a reimbursement mechanism and puts up their own Medicaid dollars

¹¹⁶ Keers-Sanchez, *supra* note 8, at 573.

¹¹⁷ Susan J. Landers, *Doctors Resent Being Forced to Find, Pay for Interpreters* (Nov. 20, 2000), available at

<http://www.ama-assn.org/amednews/2000/11/20/gvsa1120.htm>.

¹¹⁸ Keers-Sanchez, *supra* note 8, at 573.

¹¹⁹ Rui Kaneya, *Ailing System: Hospitals, Clinics Lack Interpreters* (Sept. 2002), available at

<http://www.chicagoreporter.com/2002/9-2002/interpreter/interpreterprint.htm>.

¹²⁰ Gilmore, *supra* note 110. California's Medicaid program pays only \$20 for a physician office visit. Cost, therefore, is a major concern for state physicians who must pay \$150-\$180 per patient visit for interpreter services. Markian Hawryluk, *AMA: Doctors Shouldn't Pay for Translation* (Jan. 2002), available at www.ama-assn.org/sci-pubs/amnews/pick_02/gvsb0114.htm.

¹²¹ Gilmore, *supra* note 110. Some providers resent the fact that payment received by interpreters exceeds their Medicaid reimbursement.

¹²² NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 16.

first.¹²³ Currently, only ten states reimburse providers for language services and match federal funds – Hawaii, Idaho, Kansas, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah, and Washington.¹²⁴ The Center for Medicare and Medicaid Services (CMS) has reminded states that federal matching funds are available for states' expenditures on written translation activities and services, and oral interpretation provided by staff interpreters, contract interpreters, or through a telephone service, to SCHIP or Medicaid recipients.¹²⁵ Unfortunately, some states, faced with tight budgets, have not designated state funds to pay their share of the Medicaid/SCHIP match.¹²⁶ Other states view language services as part of providers' costs of doing business and bundle the cost of language services into the providers' general reimbursement rates.¹²⁷ Regrettably, this bundled payment rate is dreadfully insufficient to cover the providers' actual costs.¹²⁸

Even in those states that have designed a mechanism for reimbursing language assistance services, rates range from only \$7 to \$50 per hour.¹²⁹ With anecdotal accounts suggesting that translation services may cost up to \$400, a \$40 state reimbursement hardly seems sufficient even with a federal match.¹³⁰ Moreover, healthcare providers that receive federal funds must ensure language access for all of their patients, not just Medicaid and SCHIP enrollees.¹³¹ Thus, a gap exists between existing federal funding and the services providers are

¹²³ Keers-Sanchez, *supra* note 8, at 573.

¹²⁴ NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 16. The amount states get from the government for language services depends on the state, the program, and how the state chooses to be reimbursed. Each state has a different federal "matching" rate – the percentage of costs for which the government is responsible – and may cover the costs of interpretation as either a covered service or an administrative cost.
Id.

¹²⁵ *Id.* at 15.

¹²⁶ *Id.* at 16.

¹²⁷ *Id.*

¹²⁸ NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 16.

¹²⁹ *Id.* at 20.

¹³⁰ *Id.*; Gilmore, *supra* note 100. In an effort to emphasize the high costs physicians will incur to fulfill the mandate, a letter from fifty state medical societies was sent to Tommy Thompson, Secretary of DHHS, referring to a physician who was forced to hire an interpreter for \$237 but only reimbursed \$38 by Medicaid for the visit. *Letter from 50 State Medical Societies to HHS Secretary Thompson Regarding Medicare Limited English Proficiency Mandate* (Apr. 2001), available at <http://www.ama-assn.org/ama/pub/article/6073-4543.html>.

¹³¹ NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 20.

required to make available.¹³² Although providers may be reimbursed \$40 per hour for language assistance they provide to Latino patients on Medicaid or SCHIP, they are forced to absorb that cost for other patients on private health plans.¹³³

2. A Proposal to Shift the Burden to Managed Care Organizations

Some experts make a strong financial case for health plans to offer accessible services to LEP patients.¹³⁴ Advocates assert that healthcare organizations that offer language assistance may attract more patients; receive higher score on quality measures, such as patient satisfaction; and avoid unnecessary diagnostic tests and hospitalizations.¹³⁵ Additionally, the relative cost of language services to managed care organization would be minimal. In 2002, the Office of Management and Budget (OMB) reported to Congress that language services would cost an extra 0.5 percent of the average cost per visit.¹³⁶ Since some managed care corporations are under contract with states, states can draft terms requiring the provision of language services.¹³⁷ However, prior legislative efforts to have interpreters provided by private state insurers have been strongly opposed and defeated by the insurance lobby.¹³⁸ Moreover, insurance companies are unlikely to volunteer to pay for these services as long as the DHHS requires providers to pay the interpreter bill.

B. The Availability of Medical Translators

Aside from cost considerations, there is no guarantee that translators will be available when needed.¹³⁹ Many physicians stress that qualified

¹³² *Id.*

¹³³ *Id.*

¹³⁴ See generally, Michael Bailit et al., *Beyond Bankable Dollars; Establishing a Business Case for Improving Health Care* (Sept. 2004), available at www.cmf.org.

¹³⁵ See Weiss, *supra* note 95, at 39.

¹³⁶ Office of Management and Budget, *Report to Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for People with Limited English Proficiency* (Mar 14, 2002), available at <http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf>.

¹³⁷ NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 19.

¹³⁸ See *Wilson's Vetoed Bills Return, Get a Go-Slow Reception*, 9 CAL. WORKER'S COMP ADVISOR (Feb. 24, 1999). In California, prior legislative efforts to have an interpreter provided during worker's compensation examinations were unsuccessful and strongly opposed by the Self-Insurers Association, which does not want to pay for interpreter services. *Id.*

¹³⁹ Keers-Sanchez, *supra* note 8, at 569.

interpreters are not always available for drop-in visits or when clinical appointments run late or overtime.¹⁴⁰ It is not always practical to get an interpreter to the hospital when needed, and “[b]y the time the interpreter arrives, the patient may [have already] left or the physician may be busy with another patient.”¹⁴¹ Though some services offer simultaneous interpretation, language assistance does add additional time to an office visit.¹⁴² In emergency situations, the physician may not have time to communicate through an interpreter.¹⁴³ Furthermore, it may be difficult to hire interpreters because of limited availability in many rural areas,¹⁴⁴ or in certain states such as Alaska, Arkansas, Georgia, Indiana, Iowa, Kentucky, Minnesota, and South Carolina.¹⁴⁵ Urban areas fare no differently. These jurisdictions face separate challenges and obstacles, such as accommodating the numerous languages prevalent in the community.¹⁴⁶

C. The Trend Towards Formal Interpreters

In an effort to provide optimal care and control costs, many healthcare providers rely on informal (*ad hoc*) interpreters such as family members, friends, or bilingual hospital personnel.¹⁴⁷ Whether formally trained interpreters are truly more effective than informal interpreters is debatable.¹⁴⁸ Studies comparing formal and informal methods indicate that while fewer errors occur with formal interpreters, their affect on therapeutic outcome is inconclusive.¹⁴⁹ Nevertheless, because significant problems can arise from the use of informal interpreters, there is a trend towards using trained professionals as interpreters.

Ad hoc interpreters may be a viable option for several reasons. First, it is administratively easier for patients to assume the burden of

¹⁴⁰ See *id.* at 572.

¹⁴¹ Julie A. Jacob, *Better Interpretation Is Just a Phone Call Away* (June 2001), available at http://www.ama-assn.org/sci-pubs/amnews/pick_01/bil20611.htm.

¹⁴² See RL Kravitz et al., *Comparing the Use of Physician Time and HealthCare Resources Among Patients Speaking English, Spanish, and Russian*, 38(7) MEDICAL CARE 728, 734 (2000). A study measuring the effect of LEP on the duration of clinical visits indicated that 12.2 additional minutes were added to an office visit when a professional interpreter for Spanish-speaking patients was utilized. *Id.*

¹⁴³ Keers-Sanchez, *supra* note 8, at 572.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.* There are more than 100 languages spoken in the Chicago public school system alone. *Id.*

¹⁴⁷ Keers-Sanchez, *supra* note 8, at 569.

¹⁴⁸ See *id.*

¹⁴⁹ *Id.*

providing their own means for language assistance. Patients should be able to rely on someone from their families to translate because using a family member would “ensure that the interpreter had a similar cultural background [as] the patient... making the patient more comfortable.”¹⁵⁰ Formal translators may not understand the subcultures within a group speaking a common language.¹⁵¹ This has a substantial impact on how certain words are to be translated and thus formal translators are not as effective as family members.¹⁵² Second, LEP patients may not feel comfortable discussing personal medical problems around an interpreter, who is a stranger to the patient.¹⁵³ Finally, many physicians believe that having a family member present may help patients adhere to their course of treatment because they may remember instructions the patient has forgotten.¹⁵⁴

However, although some family members diligently translate everything the physician discusses, others may fail to interpret a message correctly.¹⁵⁵ Competent medical interpretation requires sufficient skill to convey technical information accurately and precisely in two languages.¹⁵⁶ Family and other untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers.¹⁵⁷ They do not understand the need to interpret *everything* the patient says and may summarize information instead.¹⁵⁸ Family members may also inject their own opinions and observations, impose their own values and judgments as they interpret, or desire to shield the patient from

¹⁵⁰ Tanya Albert, *Medical Interpreter Rule to Get Further Study from AMA Board*, AMERICAN MEDICAL NEWS, May 21, 2001, at 6.

¹⁵¹ See Kaneya, *supra* note 119.

¹⁵² *Id.*

¹⁵³ Keers-Sanchez, *supra* note 8, at 570.

¹⁵⁴ Albert, *supra* note 150, at 6.

¹⁵⁵ Keers-Sanchez, *supra* note 8, at 570.

¹⁵⁶ NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 571.

¹⁵⁷ See Glenn Flores et al., *Errors in Medical Interpretation and their Potential Clinical Consequences in Pediatric Encounters*, 111 PEDIATRICS 6 (2003). A study was conducted comparing the proficiency of hospital staff interpreters with ad hoc interpreters (nurses, social workers, and family) to determine the frequency, types, and clinical consequences of errors in medical interpreting. *Id.* There were a total of 396 errors recorded. *Id.* at 8. They included omission of a word/phrase uttered by parent, physician, or child (52 percent), using the incorrect word/phrase (16 percent), inappropriately substituting words/phrases (13 percent), providing personal views (10 percent) and inappropriate addition by the interpreter (8 percent. *Id.* at 6. The study found that 63 percent of all errors had potential clinical consequences and errors made by *ad hoc* interpreters were significantly more likely to have clinical consequences than those made by hospital interpreters (77 percent vs. 53 percent). *Id.* at 9.

¹⁵⁸ NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 43.

negative or embarrassing news.¹⁵⁹ Moreover, family members themselves may have limited English abilities or may be unfamiliar with medical terminology;¹⁶⁰ “as communications are distorted, misdiagnoses of medical conditions are likely, thereby compromising patient welfare.”¹⁶¹ In addition, patients may not want to disclose sensitive or private information around family members and friends; this incomplete information may jeopardize a provider’s ability to correctly diagnose a condition.¹⁶² Requiring a patient to provide family to interpret could also violate a patient’s right to privacy. Trained interpreters, on the other hand, can ensure confidentiality and prevent conflict of interest.¹⁶³

D. Physicians Cannot Ensure Interpreter Competence Without Guidance

Unlike translators for the hearing impaired, there are no national standards for medical translators.¹⁶⁴ This makes it difficult to determine if an interpreter is qualified.¹⁶⁵ However, the DHHS guidelines require providers to not only provide interpreters, but ensure they are qualified and competent.¹⁶⁶ Because many factors are involved in ensuring culturally and factually correct translation,¹⁶⁷ a consistent or standardized system to determine interpreter competence is impossible without guidance.¹⁶⁸

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*. A child, rushed out of school to a nearby hospital where her mother lay, was asked to explain to her mother that the cancer would require surgery, chemotherapy, radiation. Unable to find appropriate words in Cantonese, the child described the situation in basic terms leaving gaps in the explanation. Since she did not know how to say “surgery,” she explained to her mother the treatment would require needles, knives, tubes, and cuts in her body. This personal account of a child serves to illustrate the difficulty with expecting ad hoc interpreters to accurately convey information between physician and patient. *Id.*

¹⁶¹ Keers-Sanchez, *supra* note 8, at 571.

¹⁶² NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 43. For example, a battered woman is not likely to reveal the scope and cause of her injuries when her batterer husband is asked to interpret for her.

¹⁶³ *Id.*

¹⁶⁴ See *Interpreter Practices: Overview of Role and Practice Issues*, DIVERSITY RX (Sept. 2000), <http://www.DiversityRx.org/html.moipr1.htm>.

¹⁶⁵ See *id.*

¹⁶⁶ See 65 FED. REG. 52,762.

¹⁶⁷ See *infra* Part IV.C.

¹⁶⁸ See Keers-Sanchez, *supra* note 8, at 571.

PART IV: POLICY RECOMMENDATION

Currently, federal funds recipients are responsible for creating, managing, and funding language programs for LEP patients.¹⁶⁹ While the DHHS and DOJ have issued recommendations, these generalized guidelines provide limited guidance or assistance in implementing competent language services within the particulars of an individual practice. This burden has created access problems where providers withdraw from offering services to beneficiaries of government programs.¹⁷⁰ A strategy that alleviates some of the burden placed on physicians and hospitals needs to be developed to assure that all patients receive meaningful access to care.¹⁷¹ In addition, because healthcare is a complex system that involves the interests of many entities including the state and federal government, each component should share the cost burden and responsibilities for assuring competent language assistance services.

A. Language Needs Should be Assessed by the Community or Local Government

An assessment of the types of languages spoken in a given community is the first step to ensuring meaningful access to care.¹⁷² However, it is unfair to expect all providers, regardless of their practice size or financial situation, to accurately determine the number and language needs of LEP persons in their service area. Hospitals and group practices have data regarding patients that have accessed healthcare. But these data cannot be used accurately to predict the needs of the community since minorities that experience communication barriers disproportionately access the system.¹⁷³ While it is true that hospitals and individual providers can obtain this information from contact community groups and schools, excessive amounts of healthcare resources would be utilized to gather data that may duplicate government census data.¹⁷⁴ The government shares an interest in these statistics; they are used in making legislative decisions that affect state services.¹⁷⁵ A program that requires that governments share this

¹⁶⁹ See 65 FED. REG. 52,762

¹⁷⁰ Keers-Sanchez, *supra* note 8, at 574.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ See IOM, *supra* note 9, at 191.

¹⁷⁴ Keers-Sanchez, *supra* note 8, at 575.

¹⁷⁵ *Id.*

information would eliminate the need to expend precious healthcare dollars to retrace the government's footsteps.¹⁷⁶

B. Telephone Interpretation Services Provide a Cost-Effective Solution to the Access Problem

In light of these obstacles faced by healthcare providers when ensuring competent services,¹⁷⁷ telephone interpretation services represent a tremendous potential asset to LEP patients and federal funds recipients who provide for their care.¹⁷⁸ First, telephone services provide translation services in over 150 languages removing the burden on federal funds recipients to find local interpreters for uncommon languages.¹⁷⁹ Second, these telephone interpreters can ensure that patients receive vital and potentially life-saving information, such as medication instructions.¹⁸⁰ Third, while hired interpreters can range from \$25 to \$60 per hour, telephone interpreters charge \$1.50 to \$4.50 per minute which may result in substantial savings when a provider's time with an LEP patient averages considerably less than one hour.¹⁸¹ Furthermore, telephone interpreters may be available to federal funds recipients and patients 24/7; hired interpreters, bilingual staff, and volunteer interpreters provided through language assistance programs are not so available.¹⁸²

However, telephone interpretation is not without faults. Telephone interpreters are not present to assess the body language and gestures of an LEP individual; this "nonverbal communication makes up a large portion of language."¹⁸³ In addition, few physicians have videophones¹⁸⁴ and many do not even have telephones in examination rooms.¹⁸⁵ These operational issues may make telephone translation services ineffectual. Still, for those practices that can provide

¹⁷⁶ *Id.*

¹⁷⁷ *See supra* Part III.

¹⁷⁸ Glasser, *supra* note 16, at 479.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.* An Access Project survey revealed that 27% of LEP participants do not understand their medication instructions without an interpreter while only 2% were health illiterate after an interpreter was provided. *Id.*

¹⁸¹ *Id.* at 482.

¹⁸² Glasser, *supra* note 16, at 479.

¹⁸³ Keers-Sanchez, *supra* note 8, at 572.

¹⁸⁴ Videophones are required to provide sign language services to hearing impaired patients.

¹⁸⁵ E-mail from Cindy Brach, Professional Staff Member, Agency for Healthcare Research and Quality, to Siddharth Khanijou (Nov. 3, 2004, 11:36:35 CST) (on file with author).

videophones or telephones in examination rooms, this option may provide a cost-effective solution while minimizing loss of communicative information.

Competence can be ensured if the DHHS developed national standards with which all telephone interpreters must comply to obtain DHHS certification or license.¹⁸⁶ Certification requirements could include representing language assistance for an appropriate number of languages, using qualified interpreters, assuring the reliability of the service, mandating that the interpreters are sufficiently trained in medical terminology, and guaranteeing that the interpreters are available to providers and patients at all times.¹⁸⁷

C. A Model for Ensuring Linguistically and Culturally Competent Formal Translators

Although telephone interpretation services may suffice in the majority of healthcare encounters, there remains a need for formal interpreters. Some providers cannot use telephone services because their office building cannot be fit to provide telephones in examination rooms. In other instances, such as end-of-life discussions where the information conveyed is of a delicate and private nature, telephone interpretation may not be the most sensitive means of communication. In these situations, formal interpreter with interpreting skills in the healthcare context is necessary. Again, the DHHS places the burden on federal funds recipients to develop a comprehensive policy on language services, formulate standards for medical interpreters, and ensure interpreter competence.¹⁸⁸

Skilled interpretation requires mastery of two languages and proper training.¹⁸⁹ Because language is much more than a list of words, translation is about much more than replacing a set of words in one language with a set of words in another.¹⁹⁰ Appropriate translation must be a communicative activity that aims to create new texts that convey

¹⁸⁶ Glasser, *supra* note 16, at 481.

¹⁸⁷ *Id.*

¹⁸⁸ Keers-Sanchez, *supra* note 8, at 569.

¹⁸⁹ Interpreters and Interpreting, <http://www.hablamosjuntos.org/is/default.index.asp>.

¹⁹⁰ See Developing Quality Spanish Language Materials, <http://www.hablamosjuntos.org/sm/index.asp> (“Imagine a limited English speaking patient... [with] chicken pox looking up the words “chicken” and “pox” in an Spanish-English dictionary, or someone trying to figure out what spots on their liver have to do with patches on his arm”).

the original message intended, not simply the words.¹⁹¹ Sensitivity to a patient's culture is of paramount importance to this endeavor.¹⁹²

The first step in assessing the abilities of a person serving as an interpreter is testing language capabilities.¹⁹³ Since no national standards for competency exist, the Robert Wood Johnson Foundation has funded a project called *Hablamos Juntos* to develop affordable models for healthcare organizations to offer Spanish language services to Latino populations.¹⁹⁴ Demonstration sites are piloting the Language and Interpreter Skills Assessment (L&ISA) program, a series of "four computer-administered assessment tools that measure language proficiency and interpreting skills in the health care context."¹⁹⁵ Individual interpreter and bilingual workers are assessed for basic skills, including listening and reading comprehension, literacy in Spanish, attention to details and sequences, social and cultural appropriateness, and general language ability and terminology, using a computer based assessment tool developed from authentic data.¹⁹⁶ Since this is a national pilot evaluating a newly developed tool, test results are not provided.¹⁹⁷ However, test takers receive an Individualized Improvement Plan which identifies their strengths and weaknesses and provides suggestions to improve current skills.¹⁹⁸

In addition, demonstration sites are forming partnerships with local educational institutions to establish college level health interpreter training programs.¹⁹⁹ This intervention seeks to place interpreter training in educational institutions, and thus reduce the burden on healthcare organizations. Though *Hablamos Juntos* is specifically designed to foster competency in English-Spanish translation, similar methods can be used to institute training programs for any language needs identified in a particular community.

¹⁹¹ *See id.*

¹⁹² *See Interpreter Training and Education*, <http://hablamosjuntos.org/is/training/default.training.asp>.

¹⁹³ *See Interpreter Testing*, <http://hablamosjuntos.org/is/testing/default.testing.asp>.

¹⁹⁴ *Hablamos Juntos*, <http://hablamosjuntos.org/default.about.asp>.

¹⁹⁵ *See Interpreter Testing*, <http://hablamosjuntos.org/is/testing/default.testing.asp>.

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *See Hablamos Juntos*, <http://hablamosjuntos.org/default.about.asp>.

D. Provider Remuneration for Interpretation Services Assures LEP Patients Meaningful Access to Care

Two problems exist with the current scheme for reimbursement to federal funds recipients who utilize interpretation services: (1) federal “matching” funds that reimburse for provided medical interpretation services are available only after a state adopts its own Medicaid interpreter reimbursement scheme, and (2) reimbursement is available only to Medicaid or SCHIP enrollees despite a mandate that federal funds recipients make interpretation services available to *all* patients.²⁰⁰ Many recipients are concerned that Medicaid and Medicare patients will be denied services as a result of the financial burden that the DHHS guidelines impose. Indeed, some physicians have withdrawn participation in Medicaid programs despite state and federal reimbursement; this problem is even more acute in states that bundle the cost of language services into the providers’ general fee-for-service reimbursement rate.

Unfortunately, the healthcare system has no cheap fix. Although some physicians resent payment received by interpreters that exceeds their own reimbursement, an incentive that sufficiently reimburses providers for utilizing language assistance programs can ensure the well-being of LEP patients.²⁰¹ Ideally, this reimbursement should be available to *all* patients that require language assistance, not simply Medicaid or SCHIP enrollees, to offset the burden of providing these services. Once a state has invested the initial resources to established a program for its Medicaid and SCHIP beneficiaries, the additional cost to expand the program to other LEP patients would likely be minimal.²⁰² Therefore, an incentive that increases the reimbursement for language assistance services will ease the undue hardship that the DHHS guidelines have placed on providers, ensure that federal funds recipients will be able to see Medicaid and SCHIP patients without financial strain, and provide patients with security in their efforts to communicate effectively with providers.²⁰³

CONCLUSION

Effective communication is a physician’s best diagnostic tool. Absent open and uninhibited dialogue, the physician-patient relationship is

²⁰⁰ See NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 15-16.

²⁰¹ See Glasser, *supra* note 16, at 483.

²⁰² NATIONAL HEALTH LAW PROGRAM, *supra* note 5, at 20.

²⁰³ Glasser, *supra* note 16, at 483.

compromised and misdiagnoses can result in serious health consequences. It is widely accepted that language discordance between patient and physician oftentimes creates a communication barrier that threatens meaningful access to medical care. In such circumstances, language services are necessary to ensure quality communications in the healthcare setting for LEP patients. Unfortunately, healthcare providers have been unreasonably burdened by interpretation requirements placed on them by agencies implementing Title VI.²⁰⁴ Recent DHHS guidelines, claiming to interpret pre-existing legal duties, state that it is the sole responsibility of providers that receive federal funds to establish, implement, and maintain policy that allows for effective communication with LEP persons. Although individuals have no private right of action against physicians who fail to provide interpreters, the threat of tort liability or administrative sanctions is strong enough to compel healthcare providers to offer services they may be unable to afford.²⁰⁵ Others choose simply to withdraw participation in Medicaid programs to avoid economic strain or possible liability -- further amplifying the access problem.

In fairness, all entities that have an interest in ensuring competent medical care should share in the responsibilities and burdens necessary to achieve this goal.²⁰⁶ The responsibility of assessing the language needs of a community, ensuring culturally competent interpretation, and paying for services should shift to local educational institutions and state or federal governments. This approach would allow providers to concentrate on appropriate diagnoses and treatment through the utilization of local- or state-sponsored language assistance programs certified as linguistically and culturally competent. This incentive would remove language as a healthcare access barrier by bridging the communication gap.

²⁰⁴ Keers-Sanchez, *supra* note 8, at 578.

²⁰⁵ *Id.*

²⁰⁶ *Id.*