Medical Interpreting in the United States

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The United States has a great, yet unrecognized need for medical interpreters. Its culturally diverse population often faces barriers to critical health and social services.

This presentation will provide an overview of the current situation and efforts to improve access to healthcare for people who do not speak English well.

According to 2009 estimates, the U.S. population is about 308,034,000[1], more than 245 languages are spoken in the U.S. and 44 million persons are "limited English proficient." [2]Language barriers often result in an inability to access healthcare, unsatisfactory encounters, and possible negative personal or healthcare outcomes.

The U.S. also receives approximately 60,000 refugees each year. Refugee arrivals in FY 2008 included 13,755 from Iraq, 12,582 from Myanmar (Burma), 5,257 from Iran, 5,279 from Thailand, 5,244 from Bhutan, and 4,178 from Cuba.[3]Refugees often speak only languages of limited diffusion, making it difficult to find qualified interpreters to communicate with them.

U.S. Federal law and guidelines require that all organizations that receive federal government funding must provide meaningful access to their services for individuals with limited English proficiency.[4]The first ruling under Title VI of the Civil Rights Act of 1964 states that, "No person in the United States shall, on grounds 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." [5]

The federal Department of Health and Human Services and the courts have applied this statute to protect national origin minorities who do not speak English well. Thus, recipients of federal funding must take reasonable steps to ensure that people with limited English proficiency have meaningful access to their programs and services.[6]

According to common Sense Advisory, "there are between 15,000 and 17,000 people currently performing [spoken language] medical interpreting work in the United States." These include individuals who provide interpreting services a) as a primary profession (i.e., full-time staff

1- U.S. Census Bureau, U.S. PopClock Projection. Last accessed 11/30/09.

2- U.S. Census Bureau, Census 2000 Supplementary Survey estimates

3- Office of Refugee Resettlement, http://www.acf.hhs.gov/programs/orr/data/fy2008RA.htm. Last accessed 11/30/09.

4- National Health Law Program & The Access Project, Language Services Action Kit, 2003.

5- U.S. Department of Justice, Civil Rights Division, Title VI of the Civil Rights Act, http://www.justice.gov/crt/cor/byagency/28cfr421.php. Last accessed 11/30/09.

6- National Health Law Program & The Access Project, Language Services Action Kit, 2003.

interpreters, agency employee interpreters, and contract interpreters), b) volunteers of bilingual staff, and c) remove interpreters working in and outside the U.S.[7]

Research conducted, in part, by The Yale School of Public Health reported in 2009 that "Resident Physicians are 'getting by' instead of using professional interpreters with patients." Researchers found that "many physicians fail to use readily available interpreters with their non-English speaking patients, opting for 'getting by' with their own limited foreign language skills or using a patient's friend or family member."[8]

"The Health and Human Services guidance describes various options available for providing oral language assistance, including the use of bilingual staff, staff interpreters, or contract interpreters… The guidance stresses that interpreters need to be trained and competent, though not necessarily formally certified, and discourages the use of friends and family members, particularly minors, as interpreters…"[9] Competency requires more than self-identification as bilingual. Competency to interpret does not necessarily mean formal certification as an interpreter, although certification is helpful. Where individual rights depend on precise, complete, and accurate interpretation or translations, particularly in the context of administrative proceedings, the use of certified interpreters is strongly encouraged.[10]Most states require the use of certified court interpreters for trials and other legal settings; however, no such requirement exists for healthcare settings.

Furthermore, the Department of Health and Human Services specifies that interpreters must a) demonstrate proficiency in and ability to communicate information accurately in both English and in the other language; b) employ the appropriate mode of interpreting (e.g., consecutive, simultaneous, summarization, or sight translation); c) knowledge in both languages of any specialized terms or concepts peculiar to the recipient's program or activity; d) knowledge of any particularized vocabulary and phraseology used by the LEP person; 3) understand and follow confidentiality and impartiality rules; f) understand and adhere to their role as interpreters without deviating into other roles —such as counselor or legal advisor—where such deviation would be inappropriate.[11]

7- Common Sense Advisory, Is There a Market for Healthcare Interpreter Certification? http://www.globalwatchtower.com/2009/10/13/certification-market/ Last accessed 10/13/09.

8- Yale School of Public Health, http://publichealth.yale.edu/news/jan09/gettingby.html. Accessed 2/1/09.

9- National Health Law Program & The Access Project, Language Services Action Kit, 2003.

10-Health and Human Services Department, Guidance to Federal Financial Assistance Recipients Regarding
Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons http://www.justice.gov/crt/cor/lep/hhsrevisedlepguidance.php. Accessed 2/1/09.

11- Idem.

In addition to the longstanding Civil Rights Act of 1964, several states have found the need to reinforce the message through state legislation. The following states have recently passed legislation about language access: a) In California, Health Maintenance Organizations are required to provide language assistance, effective January 1, 2009; b) in Minnesota, the Interpreter Services Quality Initiative was launched in May 2008; c) New York issues State Health Care Regulations in September 2006; d) Oklahoma launched its Health Service Interpreter Certification Program in September 2005; e) Texas created an advisory committee to establish qualifications for healthcare interpreters in 2009; and Utah launched Healthcare Interpreter Certification in 2009.

Before many of these state laws were passed, efforts were underway at the national level to develop interpreter certification. In the beginning, the National Council on Interpreting in Health Care, the Massachusetts Medical Interpreters Association, the California Healthcare Interpreters Association and, more recently, the American Translators Association joined forces for this purpose. The table below outlines the activities leading to national certification from 1995 through July 2009.

YEAR	ACTIVITY
1995	Washington becomes the first state to certify Medical Interpreters
1996	MMIA & EDC publish first Standards of Practice
2001	NCIHC publishes paper on interpreter role
2001	Oregon passes law to develop qualification/certification of medical interpreters
2002	CHIA publishes Standards of Practice
2003	MMIA, CHIA, and NCIHC co-pilot a certification test for Spanish interpreters
2003	Indiana sets up a commission to develop a certification process
2004	NCIHC publishes National Code of Ethics
2005	NCIHC publishes National Standards of Practice
2005	CHIA, MMIA and NCIHC issue joint letter of support for the National Code of Ethics and National Standards of Practice
2005	TAHIT is formed and Texas HB 1341 filed by Rep. Strama (Austin)
Apr 2007	The Massachusetts Medical Interpreter Association changes its name to the International Medical Interpreter Association
May 2007	Language Line Services & the International medical Interpreters Association hold the 1st Annual National Certification of Medical Interpreters Forum

Jun 2007	The Expert Panel on Certification meets in Minnesota. Forms coalition with representatives from CHIA, IMIA, NCIHC, etc.
Dec 2007	NCIHC, ATA, CHIA, and IMIA form the National Coalition for Healthcare Interpreter Certification (NCC)
May 2008	Global Advisory Council launched by Language Line and IMIA
Jan 2009	Language Line and IMIA launch their own certification efforts
Mar 2009	National Board for Certification of Medical Interpreters launched
May 2009	NBCMI announces pilot phase of certification exam
May 2009	NCIHC announces development of National Standards for Healthcare Interpreter Training Programs
July 2009	Certification Commission for Healthcare Interpreters launched
Oct 2009	NBCMI launches interpreter certification exam for Spanish with promise to launch more languages in 2010

Efforts toward certification of all languages continue. The task of gaining recognition by healthcare organizations throughout the United States still lies ahead.

For further information see:

- Certification Commission for Healthcare Interpreters
  www.healthcareinterpretercertification.org/
- Families USA, Minority Health Newsletter
  www.familiesUSA.org
- Let Everyone Participate
  www.lep.gov
- National Board of Certification for Medical Interpreters
  www.certifiedmedicalinterpreters.org/
- National Health Law Program
  www.healthlaw.org
- National Council on Interpreting in Health Care (NCIHC)
  www.ncihc.org
- The Language Portal
  www.migrationinformation.org/integration/language_portal