MEDICAL INTERPRETER NEUTRALITY:
FEW VOICES OUTSIDE OF THE EXAMINING ROOM

A LITERATURE REVIEW AND RECOMMENDATION FOR
FURTHER RESEARCH ON IMPROVING LINGUISTIC ACCESS IN
HEALTH CARE SETTINGS

WRITTEN BY
JARED A. ERDMANN

WITH SUPPORT FROM
UNIVERSITY OF MINNESOTA, SCHOOL OF PUBLIC HEALTH
&
HACER:
HISPANIC ADVOCACY AND COMMUNITY EMPOWERMENT THROUGH RESEARCH

Table of Contents

Acknowledgements

I would like to thank the University of Minnesota, School of Public Health for providing the funding to conduct the research for this project. The project began with the inspiration of Dr. Lynn Blewett, my academic advisor and the research was carried out during my summer field experience with HACER, Hispanic Advocacy & Community Empowerment through Research. I appreciate the support and input from Dr. Blewett as well as Claudia Fuentes, Executive Director of HACER, to complete the final review. Lastly, I appreciate the invaluable anecdotes and training that Silvia McCallip provided during the Introduction to Interpreting Course in the Program for Translation and Interpretation at the University of Minnesota. Only with this training have I been able to begin to grasp the dilemmas and challenges medical interpreters face throughout this country and all over the world. Thank you all!

Introduction

A professional medical interpreter's role is to convert effectively and accurately the meaning of an oral message in a source language to an oral message in a target language (Downing, 1992). The medical interpreter must perform this task without compromising the self-determination of the patient or health care provider and without violating the privacy and confidentiality of the patient. He/she must recognize his/her professional limits and convey messages that are true to the original oral message. Since trained medical interpreters serve as a communication channel part of their role as interpreters is to maintain a low profile, i.e. maintain neutrality, during medical encounters between patients and providers. To the detriment of available linguistic access literature, this low profile seems to have either intentionally or unintentionally extended beyond the examining room, ironically leaving medical interpreters' voices out of the literature.

Where are medical interpreter's opinions reflected in the current movement to improve the delivery of linguistic services in health care settings? "Patient satisfaction" and "provider satisfaction" are two common health care phrases but rarely have studies addressed "interpreter satisfaction." Some studies have addressed whether or not medical interpreters are satisfied with a particular method of interpretation, e.g. consecutive, simultaneous, remote-simultaneous, etc. However, as this literature review demonstrates no studies to my knowledge have directly asked medical interpreters about how to improve linguistic access and thus how to improve medical interpreter service delivery.

The following is a summary of the literature that includes recommendations for future research on how to begin hearing the voices of medical interpreters. First I address the background of medical interpretation. This discussion includes a profile of the current status of the limited-English proficient (LEP) population in the United States as well as a definition of LEP and the legislation that supports linguistic access in health care settings.

Second, I summarize the LEP literature to provide evidence for the need to ensure linguistic access and thus to provide medical interpretation and translation services. The

summary is divided into four sections that address studies related to: patient satisfaction, medical errors and inappropriate procedures, patient compliance and under-utilization of healthcare services. Furthermore, this summary illustrates how voices of interpreters are underrepresented in a discourse that very much affects them and the health care workers and patients they serve.

The third section describes existing medical interpreter models that healthcare centers and community-based organizations have implemented or rely upon to deliver linguistic services. They are models only in the sense of being common ways these organizations meet their demands of linguistic access. Although these models may function for providing interpreter services to the Deaf and Hard of Hearing, this review does not address specific considerations for the Deaf or Hard of Hearing. The models include: staff interpreters, bilingual staff, ad hoc and lay interpreters, contracted professional or otherwise certified interpreters, and language phone lines.

Fourth, I describe various Medicaid/SCHIP reimbursement models that some states have established. This section does not go into great detail as to how states and/or individual providers have secured mechanisms for reimbursement of medical interpreter services because the ways vary greatly across states. The main message is that most states and providers are unaware that mechanisms even exist to be reimbursed for providing these services.

Finally, I address the dilemma of statewide certification. This dilemma involves more than academic, state and policy level discussions. Limited access to language services affects individual patients, healthcare workers, administrators and medical interpreters alike. Existing literature does not address medical interpreters' perspectives on this issue. State certification faces a daunting challenge of ensuring high-quality medical interpreter services without compromising access and without making the services cost prohibitive on all levels of the US healthcare system. This section includes a discussion of the theory behind certification, its advantages and disadvantages, and the possible reasons more states have not considered statewide certification.

LEP Profile and Linguistic Access Legislation

LEP Profile

Ensuring linguistic access to health care for limited-English proficient (LEP) individuals has been a major concern in the United States for more than a decade. Limited-English proficient (LEP) individuals are people who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English. Language is just one of the many barriers that people who do not speak English confront in the US health care system (Schur and Feldman, 2001; Flores G. 2000, 1998; Wainberg, 1999; Perez-Stable et al., 1997; Clement, 1996a, 1996b; Hornberger et al., 1997; Thompson et al., 1990; Fernandez-Caballero et al., 1978). Activities such as making appointments, speaking to van drivers, staff and providers, reading prescriptions and other health-related material, all require the use of the English language in most health facilities of this country. As of 2000, approximately 47 million individuals in the US speak a language other than English at home and over 21 million of them speak English less than "very well" (Ossman, 2002).

Comparing the 1990 and 2000 censuses, the proportion of "linguistically isolated" (LI) households remained around 5 percent of all US households. LI households include those in which no member over 14 years old in the household can communicate in English. The proportion of LI households among Spanish speakers is increasing in pockets of many states, including non-border states like North Carolina, Nebraska, Georgia, Washington, Oregon and Nevada (Ponce and Penserga, 2002). For US households speaking Asian or Pacific Island languages the proportion is still around 30 percent (Ponce and Penserga, 2002). The US population is not becoming more monolingual: even some of the most remote communities of Middle America are needing to confront the linguistic challenge of providing health care services to increasingly diverse populations. What used to be a problem only in "border states," is now a challenge for health care providers all across the US.

Supporting Legislation

Health care providers, managed care plans and their patients legally must find feasible and cost-effective ways to ensure linguistic access in health care settings. This has been of particular importance since 1997 when President Clinton signed the United States Executive Order 13166 (EO13166) mandating that all recipients of federal funds ensure people who have limited English proficiency (LEP) have access to their services.

Providers that receive Medicaid/SCHIP funds, therefore are required to provide services such as bilingual staff, interpreters, and translated written materials to LEP patients or they risk losing their federal contracts (Ponce and Penserga, 2002). The following two sections summarize LEP-related legislation on the federal and state levels.

Federal Level LEP Legislation

Legislation on the federal level includes Title VI of the Civil Rights Act of 1964, the Hill Burton Act of 1946, Medicaid and Medicare regulations, regulations of federal categorical grant programs and the Emergency Medical Treatment and Active Labor Act (EMTALA). The US Department of Health and Human Services (HHS) has long recognized the provisions for linguistic access to health care in Title VI. Futhermore, the Office for Civil Rights (OCR) within HHS has consistently interpreted Title VI to require the provision of qualified interpreter services and translated materials at no cost to patients. The related laws on the federal level are:

Title VI of the Civil Rights Act of 1964

This legislation 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 benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance. EO 13166 uses language as a proxy for national origin and is intended to enforce Title VI of the Civil Rights Act of 1964 (Ponce and Penserga, 2002).

Hill Burton Act of 1946

The Hill Burton Act of 1946 encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a “community service obligation” that lasts in perpetuity (Perkins et al., 1998). The Office of Civil Rights has consistently taken the position that this obligation includes meeting the linguistic access needs of LEP individuals.

Medicaid and Medicare

Medicaid requires state programs to operate consistent with Title VI but only eight states (Washington, Utah, Maine, Hawaii, Massachusetts, Minnesota,

Montana and New Hampshire) have developed specific mechanisms to be reimbursed for linguistic access services (Ossman, 2002). Medicare provides reimbursement to Medicare-participating hospitals for bilingual services to inpatients and has initiated pilot programs using bilingual forms and educational materials.

Federal Categorical Grant Programs

Community health centers and migrant worker clinics that receive federal funding must agree to provide services in the language and cultural context most appropriate to their patients.

Emergency Medical Treatment and Active Labor Act of 1986

This act requires Medicare-participating hospitals that have an emergency department to treat patients (including women in labor) in an emergency without regard to their ability to pay. Many of the diagnosis and treatment requirements that EMTALA sets forth are difficult or impossible to meet if a hospital does not make efforts to eliminate language barriers (Schlosberg, 1999-2000).

State Level LEP Legislation

States have very diverse ways by which they meet (or do not meet) the language needs of LEP populations. Legislation that affects the obligations of each state to ensure language access includes language access laws, state civil rights laws, malpractice laws, and English-only laws. Language access laws, in particular, set forth a general responsibility for health care facilities to ensure communication with LEP patients. California has model legislation called the Dymally-Alatorre Bilingual Services Act that imposes direct obligations on state and local agencies to provide appropriate translation services. The agencies must provide translations of materials for languages that are spoken by 5 percent or more of the populations that they serve. California, Massachusetts and New York are among the few states that have passed comprehensive language access laws that detail specific guidance to providers on what they must do (Scholsberg, 1999-2000)

At least eighteen states have enacted English-only laws that make English the official state language (See Appendix A); however, even the most strict of these laws contains exceptions for law enforcement and public health activities (Schlosberg, 1999-2000). Twenty-six states have enacted legislation, but to varying degrees, that is specific to providing linguistic access to LEP populations.

Evidence of Need for Linguistically Appropriate Health Care Services

Beyond the legal mandate, providing linguistic services to LEP individuals is necessary because it impacts health outcomes. Below are four highlights from the literature that capture the main points from the following four sections in this review. They summarize findings from the literature about how not providing linguistic services in health care settings negatively impacts health outcomes and patient satisfaction.

- Patient satisfaction is lower between language-discordant patients and providers.
- Miscommunication or lack thereof between patients and providers can increase the likelihood of medical error and/or inappropriate care for LEP individuals eventually leading to higher costs.
- LEP patients who cannot communicate with their providers may be less likely to comply with treatment and other physician recommendations.
- LEP patients may be more likely to under-utilize certain health care services and language/cultural barriers might prevent them from seeking health care at all.

Patient Satisfaction

Recent studies have shown that LEP individuals who receive care from a language-discordant provider and who do not have an interpreter are less satisfied with the patient-provider relationship (Andrulis et al., 2002; Morales et al., 1999; Baker et al., 1998). Other studies have shown that the type of interpretation as well as the quality of interpretation provided during a medical encounter influences the level of patient satisfaction with provider communication (Lee et al., 2002; Kuo et al., 1999; David et al., 1998; Hornberger et al., 1996; Thompson et al., 1990).

Dissatisfaction is based on at least two factors. One factor is that language differences are inevitably accompanied by cultural differences in a medical encounter. When providers do not understand their patient's language, they might not be understanding important messages that the patient is conveying and may be overlooking important

cultural aspects which could assist the provider in treating the patient. In the literature this problem is generally referred to as a lack of "cultural competency" on the part of the provider. A provider who lacks cultural competence is a provider who does not have the ability to function effectively as an individual within the context of the patient's cultural beliefs, behaviors and needs (Cross et al., 1989). Cultural incompetence on the part of a provider could be an instance where he/she is not aware of folk illnesses or alternative healing practices in other cultures. Hispanic patients, in particular, often encounter providers who do not understand the symptoms of *empacho*, *mollera*, and *mal de ojo*, folk illnesses that are common in Latin American cultures (Flores 2000, Mendoza 2000).

A second factor is that different methods of interpretation influence the level of satisfaction of the patient, the provider and the interpreter. If the mode of interpretation chosen during a medical visit is not congenial to one or more of the parties involved, the level of dissatisfaction of one can have a negative impact on the level of satisfaction of all involved. Patients using AT&T telephone interpretation are as satisfied with care as patients using language-concordant providers, while patients using family or ad hoc interpreters are less satisfied (Lee et al., 2002). Patients are more satisfied using a family member as an interpreter whereas a provider is not as satisfied given the potential for a medical error (Kuo et al., 1999). Finally, patients and providers might prefer to wear headphones and communicate using remote-simultaneous interpretation, during which the interpreter is absent from the room and communicates through a microphone, whereas the interpreter would not because he/she would not be able to pick up on nonverbal communication (Hornberger et al., 1996).

Medical Errors and Excessive Testing

Miscommunication and lack of language concordance between patient and provider can lead to medical errors and unnecessary procedures carried out on LEP individuals. Multiple studies have shown that the use of professional interpreters can reduce the chances of miscommunication and medical errors that could have potentially adverse outcomes (Elderkin-Thompson et al., 2001; Kaufert et al., 1997; Hornberger et al., 1996; Haffner, 1992)

A physician who cannot understand the message his/her patient is communicating can only treat the patient based on nonverbal communication or possibly broken English. In

Ann Fadiman's book The Spirit Catches You and You Fall Down Fadiman asks a physician what he does in such cases that an interpreter is not available. His response was, "Practice veterinary medicine." By using a professional interpreter, the patient and provider can communicate and more effectively pinpoint necessary procedures to care for the patient, rather than having to guess about what the patient is saying. Decision-making is more cautious and expensive when non-English speaking patients are treated in the absence of a bilingual physician or a professional interpreter (Hampers et al., 2002). Patients also do not communicate as much information when faced with a physician who does not speak their language (Rivadeneyra et al., 2000; Hornberger et al., 1996; Seijo et al., 1991).

LEP patients might have to endure unnecessary and excessive testing. Carla Fogaren, a nurse and the director of Interpreter Services at Good Samaritan Medical Center in Brockton, Massachusetts gives an example of a 70 year-old, Portuguese-speaking man whom the EMT's suspected as suffering from a stroke or heart attack. Ms. Fogaren was called to interpret for the patient and was able to determine that he was only "coming down with a head cold and congestion." Without Ms. Fogaren's services, which in this case were voluntary, the hospital would have spent over $1300 in tests just to rule out heart attack or stroke. Dr. Eric Hardt, the Clinical Director of Geriatrics and Medical Consultant to Interpreter Services at Boston Medical Center, mentions that interpreter services are like diagnostic tests that are cheaper in many cases than the cheapest blood test ($28). (Comments, 1999)

Not using interpreters or language concordant providers can be harmful to LEP individuals. One study mentions that Spanish-speaking patients are at a double disadvantage in encounters with an English-speaking physician. The patients not only make fewer comments but the ones that they do make are more likely to be ignored (Rivadeneyra et al., 2000). Miscommunication or lack thereof in a medical encounter can lead to incorrect diagnoses, the wrong medication or treatment and adverse health outcomes, even hospitalization for LEP patients (Flores, 1998).

Using effective methods of interpretation during medical visits between language-discordant patients and providers improves communication but does not eliminate communication errors completely. Some of the most common errors that interpreters

make are addition, omission, condensation, substitution, and role exchange (Vasquez, 1991). A recent study found that errors in medical interpretation are common, averaging 31 per clinical encounter, and omissions are the most frequent type. Many of the errors could have clinical consequences and the errors made by untrained interpreters are significantly more likely to have adverse clinical consequences (Flores et al., 2003).

Patient Compliance

Patient compliance depends not only on a patient's knowledge and understanding regarding his/her disease, but also on his/her understanding of the treatment necessary. Even for patients with language-concordant providers, details about disease and the treatment involved can be difficult to understand. One study found that not having an interpreter greatly affected patients' perceived understanding of their disease. Only 38 percent of patients who did not have an interpreter when one was thought to be necessary said that their understanding of their condition was good to excellent. Similarly, only 58 percent reported their understanding of their treatment to be good to excellent. Ninety percent of the patients who didn't use an interpreter wished their examiner had explained better (Baker et al., 1996). In another study patients felt that compliance corresponded to understanding the side effects of the treatment given but only 53 percent of patients who needed but didn't use an interpreter compared to 84 percent of patients who needed and used an interpreter reported having the side effects of the medication actually explained to them (David et al., 1998). Finally, language concordance between patient and provider has been found not only to improve adherence to medication but to result in a significant effect on keeping office appointments (Manson, 1988).

Under-utilization of Health Care Services

Language is one of many barriers LEP individuals face in receiving quality healthcare services. Other barriers may be related to socioeconomic status, legal status, uninsurance and racial discrimination. All of these barriers combined with the inability to communicate with a health care provider can make medical visits difficult, frustrating, and unpleasant experiences for LEP individuals.

Various studies have shown a negative effect of limited-English proficiency on utilization of health care services for Hispanics (Jacobs et al., 2001; Gany et al., 1996; Valdez et al., 1993; Stein and Fox, 1990; Andersen et al., 1986). In a study about access barriers to health care for Hispanic children, parents cited language problems as the single greatest barrier (Flores, 1998). Even after adjusting for other determinants of physician visits, another study found that Hispanics with fair to poor English-proficiency reported approximately 22 percent fewer physician visits than non-Hispanics whose native language was English (Derose et al., 2000). Finally, in a study where appointment compliance rates were similar between English and Spanish-speaking patients, the LEP patients both with and without interpreters were less likely to be given a follow-up appointment after an emergency department visit (Sarver, 2000).

Organizational Models for Providing Linguistic Access

Just as LEP legislation varies by state, the models that organizations adopt to address linguistic access are also very diverse. Models of providing linguistic access are both financial and organizational. Financial models refer to the ways states have secured reimbursement for interpreter services. Organizational models, addressed in this section, refer to the structure and/or methods through which health care organizations provide medical interpreter services. Youdelman and Perkins (2002) discuss 14 medical interpreter programs from various institutions in various states. The organizational models for providing medical interpreter services that they address generally fit within the following categories.

Staff Interpreters

Organizations can have interpreters on staff who meet strict ethical and interpreting standards and who adhere to those standards when they interpret on the job. An advantage of hiring staff interpreters is that, although costly, it can ensure high quality and favorable access to interpreter services. Generally, the interpreters have some level of training and possibly even certification from a professional association or government agency. The organization can determine the qualifications of the interpreters it hires. Because staff interpreters are presumably hired for their training and expertise in interpretation, the privacy and confidentiality of the patient can be highly protected, trained or experienced medical interpreters are generally much clearer about their roles,

and are more prepared to communicate highly specialized information during a medical encounter.

Another advantage of staff interpreters is that this model, unlike the ad hoc/family member model, ensures medical interpreters are being paid for their work as interpreters. Ideally organizations also ensure that staff interpreters receive equitable protection compared to other healthcare staff against infectious diseases encountered in the workplace. Not all staff interpreters receive fringe benefits in addition to salary, but this model is conducive to encouraging mechanisms and benefits that ensure the safety and well being of interpreters.

Staff interpreters can form working relationships with providers and patients in this type of model. Patient-Interpreter and Provider-Interpreter relationships can be an advantage and a disadvantage. They are an advantage for building trust and because interpreters can get to know idiosyncrasies of working with each patient and provider. However, ethical dilemmas for the interpreters might also arise. Medical interpreters who know their patients also often remember when patients are telling different stories to different providers. The interpreter must make the decision to what extent he/she maintains his/her low profile or neutrality. Minneapolis, Minnesota, for instance, has a large, undocumented Latino population. Situations have occurred where a person who does not qualify for Medicaid sees a doctor using the identification of someone who does qualify for Medicaid. Obviously, falsification of identity poses serious health threats to the patient who is biologically different from the actual Medicaid beneficiary in terms of risks for allergies, diagnosis of health problems, etc. To what extent is the medical interpreter accountable for the health outcomes of the patient if the doctor does not even remember his/her own patient, but the medical interpreter does? Is the medical interpreter obligated to expose the individual who has falsified his/her identity? Repeated contact with the same patients and providers can bring about unique and often difficult ethical dilemmas.

The main disadvantage of hiring a staff interpreter is the high fixed costs, especially if patient encounters of a certain language are not very common. Health care providers require training on how to work with an interpreter correctly and efficiently and the organization must develop systems for making appointments internally. Another

disadvantage of hiring staff interpreters is that predicting the level of daily demand for any one interpreter is not always easy. Interpreters can become overburdened and experience burnout quickly if too few interpreters are hired in times of high demand.

Bilingual staff

Some organizations rely on bilingual staff to provide interpreter services. These staff ideally would not need training in medical interpretation since in many cases speaking in the second language is just another function of their job. Because providing bilingual services is an added job function, for example, in the case of a bilingual physician, costs are lower than hiring separate staff interpreters. The advantage of using bilingual staff is that it can ensure some level of linguistic access, albeit of limited quality depending to what extent the staff is bilingual. Proponents of hiring bilingual staff and providers say that it is currently one of the more sustainable methods of providing interpreter services because bilingual staff are less expensive, provide services that are within their everyday job functions but in the appropriate language(s), and can receive staff development training where skills need improvement.

Ad Hoc & Lay Interpreters

An ad hoc interpreter is generally a bilingual worker who leaves his/her regular duties to interpret on an as-needed basis. In some situations the bilingual staff might not be a physician or nurse, rather a janitor or receptionist who is expected to fill the need of an interpreter. Again, his/her level of being bilingual may be limited and not truly meeting the communication needs during a medical visit. Although short-term cost is minimal for ad hoc interpreters, in most cases they are untrained, may be unaware of ethical practices and professional conduct, might not be prepared to handle the specialized information communicated in the situation, and may advocate or speak for the patient rather than allowing the patient to speak for him/herself. Costs may be minimal in the short-run but if medical errors occur as a result of miscommunication, providers could risk lawsuits.

Long-term cost and ethical dilemmas are also a concern for lay interpreters such as relatives, children and/or friends who are called upon to interpret during medical visits, again with little or no training. Privacy of the patient is one important concern in the use of lay interpreters. Also, providers need to exercise caution with respect to the degree of

trust and reliance they place on children who act as interpreters. Using children to interpret, places them in unique positions of power and responsibility within the context of a parent-child or adult-child relationship. Putting a child in these positions requires decision-making and duties that otherwise would be part of the adult patient's (or parents') role. For example, obstetricians have had to obtain consent for caesarian sections or episiotomies from teenaged sons used as interpreters. Ten-year-old girls have had to interpret discussions of whether or not a dying family member should be resuscitated (Fadiman, 1997). An interpreting error that often occurs using lay interpreters is role exchange, i.e. the child, friend, or relative begins to speak or advocate for the patient rather than interpret the patient's messages.

Contracting with Professional or Certified (Medical) Interpreters

A professional interpreter is an individual with appropriate training and experience who is able to interpret with consistency and accuracy and who adheres to a code of professional ethics. A certified interpreter is certified as competent by a professional organization or government agency through rigorous testing based on consistent criteria (Working Group, 1998). Given these definitions, professional and certified interpreters offer similar benefits to staff interpreters. They are fluent in both languages, are trained not to compromise the self-determination of the patient, and follow ethical codes and practice professional conduct. Contracting with interpreters also can alleviate concerns of supply or access, but it can often be difficult to coordinate and make appointments between various agencies. Furthermore, the hiring organization should make efforts to verify the level of medical interpretation training that the contracted interpreter has received.

Contracting with certified and professional interpreters can be expensive; however, healthcare administrators do not need to pay interpreters' fringe benefits nor salary costs. Medicaid reimburses providers at an average rate of $30-50 per office visit (*Kaiser Daily Health Policy Report*, 8/27). Comparing that to the actual cost of interpreter services is disappointing for most administrators/providers. Certain languages are more common than others; the more uncommon the language, the higher the cost. Whereas an interpreter for a more common language like Spanish might receive $50-70 per hour for his/her services, an interpreter for a less common language could receive upwards of $300-400 per hour (*Kaiser Daily Health Policy Report*, 8/27). During situations where a patient does not show for his/her appointment, providers still must pay contracted

interpreters an average one-time charge of around $50 and still more depending on how far the interpreter needs to travel.

Language (Phone) Line

A language line is a telephone number that providers can call for interpreter services and pay for those services by the minute. Language lines have various advantages and disadvantages. Often times they offer more languages and in some cases they offer highly specialized interpreters. They are easily accessible as long as the cost is not prohibitive but finding an interpreter for a rare language might be a barrier. The more specialized an interpreter (i.e. the higher level of training of the interpreter) the higher the cost. The cost is $2.20 per minute for high demand languages, $2.60 per minute for specialized languages and $3.00 per minute for a certified medical interpreter (*Kaiser Daily Health Policy Report*, 8/27). Another disadvantage that organizations do not always think about when using language lines is that not all exam rooms have telephones.

Because healthcare organizations are so diverse, they often find different ways of meeting their linguistic demands. One study conducted by NACH State Policy Services contacted 22 Children's hospitals in 14 states and DC to investigate which models of medical interpreter services they use. The study found: 15 of 22 hospitals use full-time interpreters; 16 of 22 hospitals use contract agencies; 15 noted they use bilingual staff; 19 indicated that they use language (phone) lines; and 10 hospitals use volunteers or community-based organizations (Ossman, 2002). Nearly all of the hospitals noted that they use a combination of medical interpreter models to make interpreter services available when needed.

Table 1 summarizes the interpreter models described above on the basis of cost, quality and access. Since the literature does not provide comprehensive quantitative measurements of these factors, this summary is based in part on conjecture as well as anecdotal information from the literature. "Cost" refers to the fixed and semi-fixed costs of providing services within a given model. In the table cost does not include the "potential" costs or uncalculated risks of not using professional interpreters, e.g. malpractice lawsuits, medical errors, etc. "Quality" refers to the quality of communication between the patient and provider. Higher quality means a reduction in the quantity of

misunderstandings and interpretation errors between patient, interpreter, and provider. “Access” refers to the ease in which an organization or provider can use a particular method or model and the relative abundance of interpreters/bilingual providers.

Table 1 also highlights some broad administrative concerns under each category and is not intended to over-simplify. Since administrators and providers must make complex and often difficult tradeoffs to using just one model, they often choose, as the hospitals do from the NACH study, to implement more than one model at different times or a combination of models at the same time.

TABLE 1: COST-QUALITY-ACCESS SUMMARY OF INTERPRETER MODELS

Method of Interpretation	Cost	Quality	Access
Hired Interpreter on Staff	**Moderate-High** Reduced risk for the provider or organization	**High** Organization can set its own quality standards	**Moderate** May need to contract for peak demand and rare languages
Independent Contractor (professional or certified)	**High** Reduced risk for the provider or organization	**Uncertain** Medical interpretation qualifications need to be verified or agreed upon	**Moderate** More difficulty scheduling and getting interpreter to arrive on time
Bilingual Staff/Provider	**Low** Provider assumes risk as function of his/her practice	**Uncertain** Depends on degree of fluency	**Moderate** Cannot hire a bilingual provider for all languages and bilingual staff often not sufficient for high demand languages
Ad Hoc or Lay Interpreter	**Low** High risk for the provider or organization	**Low** Usually have no training or experience	**High** No educational barriers to entry and no cost prohibitions. Relies on a worker's or other person's ability to leave day-to-day tasks to interpret.
Language Line	**Moderate-High** Interpreter cannot see nonverbal communication	**Uncertain** Costs more for a certified medical interpreter and need to verify qualifications of the interpreter	**Moderate-High** Exam rooms need to have phones and companies do not always have rare languages available

Downing and Roat (2002) have written extensively on the advantages and disadvantages of different models of providing language access. They address three main categories of models including Bilingual Provider Models, Bilingual Patient Models and Interpreter Models. Table 2 summarizes the three main models and their respective sub-models.

TABLE 2: DOWNING AND ROAT, LINGUISTIC ACCESS MODELS

Bilingual Provider Models (2 types)	Bilingual Patient Model	Interpreter Models
• **Example 1**: Native Spanish-speaking providers providing services in Spanish • **Example 2:** Native English (or another language except Spanish) speaking providers providing services in Spanish	• Relies on patients' abilities to speak English • Attempts to teach patients to speak English • Otherwise known as the ESL (English-as-a-Second-Language) approach	**Ad Hoc Models** • Bilingual Clinical Staff Model (e.g. nurses act as interpreters) • Bilingual Non-clinical Staff Model (e.g. janitor acts as interpreter) • Community Service Agency Staff Model (e.g. free services through community-based organization) • Family and Friends Model **Dedicated Interpreter Models** • Staff model • Contract interpreter model • Agency model **Volunteer Model** (e.g. students) **Face-to-Face, Telephonic and Video taping**

The Bilingual Patient Model relies on getting patients to speak English and is not effective in working with LEP populations. EO 13166 was signed specifically to avoid the miscommunication and difficulties LEP patients encounter with "ESL" Models. The literature is consistent in supporting the Bilingual Provider and Interpreter Models over the Bilingual Patient Model. Furthermore, providers must make difficult tradeoffs even between the Bilingual Provider and Interpreter Models.

Financial Reimbursement Models

Only eight states have developed mechanisms to be reimbursed through Medicaid and the State Children's Health Insurance Program (SCHIP). Four states—Idaho, Hawaii, Maine, and Utah—draw down federal funds from the Centers for Medicare and Medicaid Services (CMS) as a "covered service". They receive their regular federal match. An additional four states—Minnesota, Montana, New Hampshire, and Washington—cover interpreter services as an "administrative expense." They receive 50 percent federal match (Ossman, 2002).

The states that provide reimbursement for medical interpreter services fit into four categories or models. Table 3 explains the four models but is an over simplification in the sense that the states have different conditions for hospitals. For instance, in Minnesota the state does not allow hospitals to bill for interpreter services for inpatient care because interpreter services are already factored into the state's DRG payment (Ossman, 2002).

TABLE 3:MEDICAID/SCHIP REIMBURSEMENT MODELS

States	Model of Reimbursement
HI, UT	• State pays a language service agency or agencies directly to provide services • The hospital arranges for interpreters through the agency(ies)
ID, MN, MN	• State reimburses the providers directly who in turn arrange for interpreters
MT, NH	• State reimburses the interpreters directly • Interpreters must obtain a Medicaid provider number to be reimbursed
WA	• Clients have a language designator on the monthly coupon they use as an identification card when they seek health care from participating providers • Providers schedule the services by working through regional contract brokers rather than interpreter agencies • State reimburses the contracted brokers directly

Although the states in Table 3 have secured mechanisms through which they receive federal reimbursement, CMS (Center for Medicare and Medicaid Services) as was mentioned previously has not issued a clear policy to states on how they can access

Medicaid/SCHIP funds for interpreter services. Half the battle of accessing these funds is being aware of their availability. If the policy were clearer, more states might be more forthright in trying to access funding (Ossman, 2002; Youdelman and Perkins, 2002).

The State Certification Dilemma

Only Washington has state certification for medical interpreters, but even in Washington not all medical interpreters are required to be state certified. Medical interpreters for LEP patients who are beneficiaries of public programs must be either state certified or meet standards determined by the Washington State Department of Social and Health Services (DSHS), Medical Assistance Administration (MAA). "State certified medical interpreters" in the following paragraphs refers to interpreters who have passed the state medical interpreter exams and who qualify to interpret for patients in public programs. Currently, only Washington has state certified medical interpreters.

State certification has advantages and disadvantages. The advantages are that it raises the standard of competence of medical interpreting for organizations that hire state certified interpreters and provides some barriers to interpreting for less or otherwise qualified interpreters without preventing them from being medical interpreters, i.e. without creating entry barriers to the occupation. In general, organizations or programs that are concerned with quality already encourage hiring certified interpreters and organizations that either cannot afford or are not as concerned with quality often hire or use uncertified interpreters.

The other advantage of state certification is parallel to Milton Friedman's only argument in favor of licensure. State certification could help prevent "neighborhood effects." Friedman (1962) describes neighborhood effects as negative "epidemic" effects that result from the mistakes of incompetent practitioners. For example, given a scenario of a provider who is communicating with an LEP patient by means of a medical interpreter, if the medical interpreter because of his/her incompetence or miscommunication fails to convey important messages about disease symptoms and the patient leaves the clinic consequently infecting third parties who are not initially involved, everybody might be willing to restrict the practice of medical interpreting only to "competent" interpreters to

prevent such epidemics from occurring. Presumably, organizations or programs that hire only certified medical interpreters would have a lower risk of causing neighborhood effects. Since many non-state certification/training programs already exist (See Appendix A), states need to justify the need for an additional state certification program.

A plausible justification for state certification would need to be that state certified interpreters save the state more money in fewer medical errors and inappropriate testing than uncertified or otherwise certified/accredited interpreters. The literature has not substantiated this; in fact many medical interpreters would disagree. Given that the public shares costs for public programs like Medicaid and SCHIP (State Child Health Insurance Program) any measures which could further prevent against neighborhood or "epidemic" effects would in turn benefit the public in general. Any measures that could prevent against medical errors and excessive or inappropriate testing among beneficiaries of public programs would benefit the tax-paying public. Of course, the increase in benefit from only using state certified medical interpreters must offset the costs of developing and maintaining the certification process. Again, no research has clearly quantified these costs and benefits.

A disadvantage of state certification is that any restriction on entry can reduce the amount of a service being provided. It poses the potential of limiting the population of medical interpreters, the methods through which they deliver services, and the development of new or innovative methods. Specifically, certification partially restricts the task of medical interpreting to a certain group of individuals and if the voting populace believes that someone who is not state certified could perform those tasks, state certification would be a waste of time and valuable resources. In essence, without evidence that state certified medical interpreters would cause fewer neighborhood effects than uncertified or otherwise accredited medical interpreters, state certification would only be a tool in the hands of a specific group to obtain a near monopoly position at the expense of the rest of the public.

The medical interpreting profession has two characteristics that are conducive to bringing about legislation in favor of state certification. All over the world coalitions, associations, and task forces have formed specifically in support of improving the profession of medical interpreting (See Appendix A). When restrictive legislation is

enacted, usually the politically organized members of the occupation are those who create the pressure to enact the legislation. Another unique characteristic of medical interpreting is that professional medical interpreters are possibly the only people who are capable of judging whom should be certified or qualified.

Why haven't more states adopted state certification? The reasons are threefold. First, states are concerned about access, particularly for low demand languages and costs of developing and maintaining the certification program. If states only allow state certified interpreters to provide medical interpretation services for public programs, they could risk severely limiting their pool of interpreters.

Second, interpreters, providers, states and the federal government have conflicting priorities. On the one hand, the federal government has shown its support for providing linguistic access by enacting EO13166; on the other hand, it has not provided any clear guidance or mechanisms through which states/providers can be reimbursed for medical interpreter services (Youdelman and Perkins, 2002). Many medical interpreters have not jumped on the state certification wagon because they have already been accredited or certified through a local or national association or organization and might see state certification as just one more bureaucratic hoop to have to jump through. The success of state certification could really depend on states' capacities to collaborate and/or recognize credentials of already existing international, national, regional, and/or local medical interpreter associations (See Appendix A). Regarding providers, with the implementation of EO 13166, the AMA and physicians would prefer to back out of providing services for beneficiaries of public programs than face the ever diminishing federal match and, in addition, absorb the costs for providing linguistic access (*Kaiser Daily Health Policy Report*, 8/27).

Finally, the more Medicaid beneficiaries become part of Medicaid managed care plans, the more state legislators can air-wash their hands in a time where the "green stuff" is in short supply and expect managed care organizations (MCOs) to absorb the costs of linguistic access. Currently almost 50 percent of Medicaid beneficiaries are enrolled in some type of Medicaid managed care plan.

Recommendations for Further Research

The main purpose of this project has been to consolidate the most compelling literature to date on linguistic access in health care settings and to expose the gaps in that literature. Medical interpreter perspectives are underrepresented in a discourse that greatly affects them, their employers, and the patients they serve. The literature provides evidence of the need for medical interpreters in health care settings, provides evidence of how not providing these services negatively impacts the health outcomes of LEP patients, describes the factors contributing to patient and provider (dis)satisfaction, as well as describes various medical interpreter service delivery and reimbursement models.

The literature does not address some very important issues with respect to linguistic access in health care settings, however. As is evident from this review, researchers for one reason or another have not incorporated medical interpreter perspectives in gathering information about how to improve access to linguistic services. Instead researchers have concentrated on counting medical interpreters' errors, on observing differences in the various models of medical interpreter service delivery, and on adding up the costs of high quality interpretation without regard to quantifying the benefits, and thus quantifying to true cost of providing these services both in the short and long term. To the detriment of existing literature cost benefit analyses, to effectively assist administrators in making decisions between the various interpreter models and to assist decision making with regards to state certification of medical interpreters, have not been conducted. Furthermore, researchers and policy makers need to work together to raise awareness on the state and local levels about how providers and health care institutions can create and secure their own reimbursement mechanisms for medical interpreter services.

Bibliography

Andrulis, D. Goodman, N. Pryor, C. (2002) "What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency." The Access Project.

Andersen, RM. Giachello, AL. Aday, LA. (1986) "Access of Hispanics to Health Care and Cuts in Services: A State of the Art Overview." Public Health Reports. 101(May-June):238-52

Baker, D., R. Hayes, et al. (1998 Oct.). "Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-speaking Patients." Medical Care. 36(10): 1461-70

Baker, D. R. Parker, et al. (1996). "Use and Effectiveness of Interpreters in an Emergency Department." JAMA 275(10):783-8.

Clement, D. (1996a) "Strangers in a Strange Land." Minnesota Medicine 79(5):11-14

Clement, D. (1996b) "Trading Places." Minnesota Medicine 79(5): 6-7

"Comments to MA Health Care Committee." April 8, 1999. Website: http://www.hispanichealth.org

Cross, T., Bazron, B., Dennis, K. W., and Issacs, M. R. (1989). "Towards culturally competent systems of care." Washington, DC: Georgetown University Child Development Center.

David, R. and M. Rhee (1998). "The Impact of Language as a Barrier to Effective Health Care in an Underserved Urban Hispanic Community." Mount Sinai Journal of Medicine 65(5-6):393-7

Derose, K. and D. Baker (2000). "Limited English Proficiency and Latinos' Use of Physician Services." Medical Care Research & Review 57(1): 76-91

Downing, Bruce T. (1992) Professional Interpretation: Insuring Access for Refugee and Immigrant Patients. *Program in Translation and Interpretation, University of Minnesota.*

Downing, B. and C. Roat (2002) "Models for the Provision of Language Access in Health Care Settings." National Council on Interpreting in Health Care.

Elderkin-Thompson, V., R. Silver, et al. (2001). "When Nurses Double as Interpreters: A Study of Spanish-speaking Patients in a US Primary Care Setting." Social Science and Medicine 52(9): 1343-58.

Fadiman, Ann. (1997). The Spirit Catches You and You Fall Down. *Farrar, Straus and Giroux*, New York. p. 25

Fernandez-Caballero, C., S. Otterbein, et al. (1978). “The Spanish-speaking Patient and the EMS System.” Emergency Medical Services 7(4):57-9

Flores G. Abreu M. Olivar MA. Kastner B. (1998) “Access barriers to health care for Latino children.” Archives of Pediatrics & Adolescent Medicine. 152(11):1119-25

Flores, G., M. Abreu, et al. (2000). “The Importance of Language and Culture in Pediatric Care: Case Studies from the Latino Community.” Journal of Pediatrics. 137(6):842-8

Flores, G. Laws MB. Mayo SJ. Zuckerman B. Abreu M. Medina L. Hardt EJ. (2003) “Errors in Medical Interpretation and their potential clinical consequences in pediatric encounters.” Pediatrics. 111(1):6-14

Friedman, Milton. Capitalism and Freedom. The University of Chicago Press, Chicago IL. 1962. pp. 137-161

Gany, F. and HT De Bocanegra. (1996) “Overcoming Barriers to Improving the Health of Immigrant Women. Journal of the American Medical Women’s Association. 51(August-October):155-60

Haffner, L. (1992). “Translation is Not Enough. Interpreting in a Medical Setting.” Western Journal of Medicine 157(3):255-9

Hampers, LC. McNulty, JE. (2002) “Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization.” Archives of Pediatrics & Adolescent Medicine. 156(11):1108-13

Hornberger, J., C.J. Gibson, et. al. (1996). “Eliminating Language Barriers for Non-English-speaking Patients.” Medical Care. 34(8): 845-56

Hornberger, J., H. Itakura, et al. (1997). “Bridging Language and Cultural Barriers between Physician and Patients.” Public Health Reports 112(5):410-17

Jacobs, E. A., D. S. Lauderdale et al. (2001). “Impact of Interpreter Services on Delivery of Health Care to Limited-English Proficient Patients.” Journal of General Internal Medicine 16(7): 468-74

Kaiser Daily Health Policy Report. “AMA President Says Federal Government Should Help Providers Pay for Interpreters for Non-English-Speaking Patients.” 27 Aug. 2002. Website: http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=13133

Kaufert, JM and Putsch, RW. (1997) “Communication through Interpreters in Healthcare: Ethical Dilemmas Arising from Differences in Class, Culture, Language and Power.” Journal of Clinical Ethics. 8(1):71-87

Kuo, D. and M.J. Fagan (1999). “Satisfaction with Methods of Spanish Interpretation in an Ambulatory Clinic.” Journal of General Internal Medicine 14(9):547-50

Lee LJ. Batal HA.Maseli JH. Kutner JS. (2002) “Effect of Spanish Interpretation Method on Patient Satisfaction in an Urban Walk-in Clinic.” Journal of General Internal Medicine. 17(8): 641-5

Manson, A. (1988) “Language concordance as a determinant of patient compliance and emergency room use in patients with asthma.” Medical Care. 26:1119

Mendoza, M. and M. Petersen (2000). “New Latino Immigration to Tennessee: Practicing Culturally Sensitive Health Care.” Tennessee Medicine 93(10):371-6

Morales, L., W. Cunningham, et al. (1999) “Are Latinos Less Satisfied with Communication by Health Care Providers?” Journal of General Internal Medicine 14(7):409-17

Ossman, A. (2002) “SPS Issue Brief: Reimbursement for Interpreter Services.” NACH State Policy Services. November.

Perkins, J. Simon, H. Cheng, F. Olson, K. and Vera, Y (1998) “Ensuring Linguistic Access in Healthcare Settings: Legal Rights and Responsibilities.” National Health Law Program. Web site consulted May 28, 2003: http://www.healthlaw.org/pubs/19980131lingaccess.html

Perez-Stable, E., A. Napoles-Springer, et al. (1997). “The Effects of Ethnicity and Language on Medical Outcomes of Patients with Hypertension or Diabetes.” Medical Care 35(12):1212-19

Ponce, N. and L. Penserga. (2002) “Language Access in Health Care: Why the Policy and Practice Inertia?” Harvard Health Policy Review 3(2):1-3

Rivadeneyra, R., V. Elderkin-Thompson, et al. (2000). “Patient Centeredness in Medical Encounters Requiring and Interpreter.” American Journal of Medicine 108(6):470-4

Sarver, J. and D.W. Baker (2000). “Effect of Language Barriers on Follow-up Appointments after an Emergency Department Visit.” Journal of General Internal Medicine 15(4):256-64

Schlosberg, C. (1999-2000) “Immigrant Access to Health Benefits: A Resource Manual.” National Health Law Program. 59-66. Web site consulted May 28, 2003: http://www.accessproject.org/downloads/Immigrant_Access.pdf

Schur, C. and J. Feldman. (2001) “Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured.” The Commonwealth Fund. 453 (May)

Seijo, R. Gomez, H. Friedenberg, J. (1991) “Language as a Communication Barrier in Medical Care for Latino Patients.” Hispanic Journal of Behavioral Science. 13:363

Stein, J. and S. Fox (1990). “Language Preference as an Indicator of Mammography Use among Hispanic Women.” Journal of the National Cancer Institute 82(21):1715-6

Thompson, W., T. Thompson, et al. (1990). “Taking Care of Culturally Different and Non-English-Speaking Patients.” International Journal of Psychiatry in Medicine 20(3): 235-45

Valdez, RB., AL Giachello, H Rodriguez-Trias, P Gomez, and C De La Rocha. (1993) “Improving Access to Health Care in Latino Communities. Public Health Reports. 108(September-October):534-39

Vasquez, C. and R. A. Javier (1991). “The Problem with Interpreters: Communicating with Spanish-speaking Patients.” Hospital & Community Psychiatry 42(2):163-5

Wainberg, M. (1999). “The Hispanic Gay, Lesbian, Bisexual and HIV-infected Experience in Health Care.” Mount Sinai Journal of Medicine 66(4):263-6

Working Group of the Minnesota Interpreter Advisory Committee (1998). “Bridging the Language Gap: How to Meet the Need for Interpreters in Minnesota.” St. Paul

Youdelman, M., J. Perkins. (2002) “Providing Language Interpretation Services in Health Care Settings: Examples from the Field.” National Health Law Program Website available at: http://www.nhelp.org/pubs/

Appendix A: State Table

State Table includes:

- Medical Interpreter Associations (By state and region)
- States with English-only Legislation (By state)
- Some Examples of Local Medical Interpreter Programs (By state) *Note: It is impossible to list all of the institutions in each state that provide medical interpreter services. For example, California obviously has many more institutions with medical interpreter programs than I have listed. In this table I have listed as many institutions as I could find on the web that provide medical interpreter related services for each state.*
- Links to medical interpreter lists and associations (By state and region)
- Links to medical interpreter training programs (By state and region)

The State Table is available in an electronic version with hyperlinks to the various websites upon request. Feel free to email me at jared_erdmann@hotmail.com and I will send you a copy.

See the following pages for complete State Table.

STATE TABLE OF INTERPRETER RESOURCES

(Note: This table is a summary of resources from the Internet)

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
1. Alabama		Associations • AITA: Alabama Interpreters & Translators Assoc. Organizations/Models • Jefferson County Health Department	Interpreter Services/Lists • http://www.jcdh.org/(under Health Services)
2. Alaska		Organizations/Models • Anchorage Neighborhood Health Center • Alaska Native Medical Center • Providence Alaska Medical Center • Southcentral Foundation's Primary Care Center	Reference Article • http://hmongunivers.angelcities.com/news20020312.html
3. Arizona	Yes	Organizations/Models • Good Samaritan Regional Medical Center (Phoenix) • Maricopa Medical Center (Phoenix) • Mayo Clinic (Scottsdale) • St. Joseph's Hospital and Medical Center (Phoenix)	Testing &Training • http://nci.arizona.edu/
4. Arkansas	Yes	Organizations/Models • Arkansas Dept. of Human Services, Refugee Resettlement Program • Arkansas Office of Minority Health	Interpreter Services • http://www.state.ar.us/dhs/dco/OPPD/index.html (Refugee Resettlement) • http://www.accessarkansas.org/dhs/dco/program.html - Refugee Resettlement Program • http://www.ata-micata.org/

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
5. California	Yes	Associations • CHIA: California Health Interpreters Association • CPCA: California Primary Care Association • NCTA: Northern California Translators Assoc. • SCATIA: Southern California Area Translators & Interpreters Association Organizations/Models • Alameda Alliance for Health (Alameda County) • Asian Health Services (Oakland) • Kaiser Permanente, Southern Region • La Maestra Family Clinic (San Diego) • PALS: Pacific Asian Language Services for Health (Los Angeles and Orange Co.) • Video Conferencing Medical Interpretation Project (San Francisco)	Interpreter Services/Lists • http://www.scatia.org/ • http://www.diversityrx.org/HTML/MOBISD1.htm (Kaiser description) • http://www.diversityrx.org/HTML/MOBISE2.htm (Asian Health Services Description) • http://www.languageline.com/ Testing and Training • http://www.ccsf.edu/Departments/Health_Science/interp.html (Certificate) • http://www.miis.edu/gsti-progs-iircover.html (Certificate) • http://www.reedleycollege.com/academic/departments/peandh/HeathCareInterpreter/default.htm (Certificate) • http://www.uclaextension.org/interpretation (Certificate) • http://www.interpreting.com/ • http://www.miis.edu/gsti-about-dean.html (Graduate Level) Standards (State) • http://chia.ws/standards/standards_home.htm Accreditation: • http://www.ncta.org/ (ATA)

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
6. Colorado	Yes	Associations • CAPI: Colorado Association for Professional Interpreters • CTA: Colorado Translators Assoc.	Interpreter Services/Lists • http://www.coloradointerpreters.org/ • http://www.cta-web.org/ (CTA) Standards (ATA only) • http://www.cta-web.org/ctaframeset.html
7. Connecticut		Organizations/Models • La Clinica Hispana (New Haven)	Interpreter/Bilingual Services • http://info.med.yale.edu/psych/clinical_care/clinica-hispana.html
8. Delaware		Associations • DVTA: Delaware Valley Translators Assoc.	Interpreter Services/Lists • http://www.fortunecity.de/lindenpark/kuenstler/59/dvta.htm (DVTA)
9. Florida	Yes	Associations • FLATA: Florida Chapter of ATA Coalitions • Dade County Human Services Coalition (Miami) • Florida Immigrant Advocacy Coalition (Miami) Organizations/Models • Haitian Youth of Tomorrow (Miami) • Gulfcoast South AHEC • Lutheran Social Services (Jacksonville) • Sarasota County Health Department Studies • Pilot Study: The Access Project (2002)	Interpreter Services • http://www.lssjax.org/ (Our Programs, then Refugee and Immigrant Services) Testing and Training • http://www.flahec.org/provide.html • http://www.srahec.org/multi-cultural programs.htm • University of Florida: http://www.hp.ufl.edu/ • http://www.atafl.com/ (for FCATA, Court & Legal Certification only)

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
10. Georgia	Yes	Associations • AAIT: Atlanta Association of Interpreters & Translators	Interpreter Services/Lists • http://www.aait.org/
11. Hawaii		Organizations/Models • Helping Hands Hawaii • Kalihi-Palama Health Center	Interpreter Services/Lists • http://www.helpinghandshawaii.org/bilingual.htm (Language Line) • http://www.healthhawaii.org/cover.html (Kalihi-Palama Health Center)
12. Idaho			Interpreter Services/Lists (Court only) • http://www2.state.id.us/judicial/rosters.htm
13. Illinois	Yes	Associations • CHICATA: Chicago Area Tranlators & Interpreters Assoc. Coalitions • Illinois Coalition for Immigrant and Refugee Rights Organizations/Models • HABLA Program (Lake County) • HCIS: Health Care Interpreting Services (Chicago)	Interpreter Services/Lists • http://www.chicata.org/ • http://www.diversityrx.org/HTML/MOBISE3.htm (HCIS Description) • http://www.healthreachcares.org/1-services.html (HABLA Program) • http://www.ata-micata.org/
14. Indiana	Yes	Associations • INTI: Indiana Network of Translators & Interpreters (Indianapolis)	Interpreter Services/Lists • http://www.cs.iupui.edu/~smckee/inti.html • http://ccio.org/

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
15. Iowa	Yes	Organizations/Models • Iowa Department of Human Rights • Iowa Dept. of Public Health • Mercy Medical Center, Des Moines Studies • Pilot Study: The Access Project (2002)	Interpreter Services/Lists • http://www.state.ia.us/government/dhr/la/pdfs/brochures/Interpreters-Translators.PDF • http://www.idph.state.ia.us/coveringkids/resources/Interpreters.pdf • http://www.dhs.state.ia.us/refugee/interpreter/default.asp • http://www.ata-micata.org/ Training • No longer available through the University of Northern Iowa (ITOP) Study Website • http://www.accessproject.org/
16. Kansas		Advocate Agency • KACHA: Kansas Advisory Committee on Hispanic Affairs Organizations/Models • Children's Mercy Hospital (Kansas City) • Shawnee Mission Medical Center • Truman Medical Center (Kansas City)	Interpreter Services/Lists • http://www.hr.state.ks.us/ha/html/interpret.htm (List from KACHA website) • http://www.ata-micata.org/ Training • Court Interpreter Handbook on the above KACHA web site

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
17. Kentucky	Yes	Associations • KTIA: Kentucky Translators & Interpreters Association Organizations/Models • Arras Interpretation & Translation Service, LLC • Center for Women & Families (Louisville) • County Health Dept. (Fayette) • Languages Unlimited, Inc. • Office for International & Cultural Affairs, Community Language Bank	General Interpreter Resources in the State • http://www.state.ky.us/agencies/adm/translators.htm Interpreter Services/Lists • http://www.ktialink.org/ (KTIA) • http://www.luitranslations.com/ (Languages Unlimited) • http://www.louky.org/oica/bank.asp (Language Bank Website) • http://ccio.org/
18. Louisiana			
19. Maine		Organizations/Models • Maine Medical Center	State Standards • http://www.chia.ws/standards/resources/maine_interpreters_jan2001.doc
20. Maryland		Organizations/Models • FIRN: Foreign-born Information and Referral Network (Howard County) • MONA: Maryland Office for New Americans • Holy Cross Hospital (Silver Spring)	Interpreter Services/Lists • http://www.holycrosshealth.org/ • http://www.firnonline.org/ • http://www.dhr.state.md.us/mona/

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
21. Massachusetts		Associations • MMIA: Massachusetts Medical Interpreters Association Coalitions • MIHAC: Massachusetts Immigrant Health Access Coalition • Massachusetts Immigrant Refugee Advocacy Coalition Organizations/Models • Cambridge Health Alliance (Cambridge) • Children's Hospital, Interpreter Services Dept. (Boston) • Harvard Pilgrim Health Care, Inc., Office of Diversity • University of Massachusetts Medical Center, Interpreter Services Office (Worcester)	Interpreter Services/Lists • http://www.diversityrx.org/HTML/MOBISB1.htm (Description of ISO) • http://www.diversityrx.org/HTML/MOBISD2.htm (Description of Office of Diversity) • http://www.mmia.org/ • http://www.hcfama.org/hcfa_contents.php3?fldID=64 (MIHAC) Training • http://www.mmia.org/ • http://cambridgecollege.edu/undergraduate/ (Academic Programs, then scroll down to medical interpreting) • http://www.state.ma.us/dph/bhqm/matraini.pdf Standards (MMIA) • Available by purchase: http://www.mmia.org/sop.html
22. Michigan		Associations • MITIN: Michigan Translators & Interpreters Network	Interpreter Services/Lists • http://www.mitinweb.org/ • http://www.languatutor.com/

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
23. Minnesota		Associations • MICATA: Mid-America Chapter of ATA • Minnesota Medical Assoc.:Language Assisted Interpreter Services • UMTIA: Upper Midwest Translators & Interpreters Assoc. Organizations/Models • CCCH: Center for Cross Cultural Health • Children's Hospitals & Clinics • DHS: Department of Human Services • Fairview Health Services • HCMC: Hennepin County Medical Center • Mayo Clinic (Rochester) • OMS: Office of Multicultural Services(Hennepin County) • PTI: Program in Translation and Interpreting, U of MN • Ramsey County Dept. of Health	Interpreter Services/Lists • http://www.co.hennepin.mn.us/chpcsi/oms/oms.html (OMS) • http://www.fairview.org/aboutfv/interpreter/ (Fairview) • http://www.hcmc.org/depts/slp/sl_bilingual.htm (HCMC) • http://www.ata-micata.org/ • http://www.mmaonline.net/pdf/proficiency.PDF • http://www.ppmsd.org/medical/interpreter.asp Training • http://www.cla.umn.edu/pti/ • http://www.crosshealth.com/ Standards (Countywide-Hennepin) • http://www.co.hennepin.mn.us/chpcsi/oms/lep.html
24. Mississippi	Yes		
25. Missouri		Organizations/Models • Jewish Vocational Service • Missouri Interpreters, Culture Guides, Inc. • Missouri Multicultural Network	Interpreter Services/Lists • http://www.cultureguides.com/misint.html • http://www.ata-micata.org/ Training • http://www.mssc.edu/missouri/providers/train.htm (Lists training resources in the state) • http://stlouis.missouri.org/lamp/
26. Montana			

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
27. Nebraska	Yes	Associations • NATI: Nebraska Association for Translators and Interpreters	Interpreter Services/Lists • http://www.natihq.org/ • http://www.ata-micata.org/
28. Nevada			
29. New Hampshire		Associations • URMAA: New Hampshire United Refugees Mutual Assistance Assoc. Coalitions • New Hampshire Minority Health Coalition, The Access Project (2002) Organizations/Models • Southern New Hampshire Area Health Education Center (SNHAHEC)	Interpreter Services/Lists • http://www.geocities.com/urmaa2001/index.html • http://www.geocities.com/urmaa2001/design.html
30. New Jersey		Organizations/Models • International Institute of New Jersey • Translators Cafe	Interpreter Services/Lists • http://www.translatorscafe.com/Cafe/News.asp • http://www.iinj.org/ Training workshops (Free) • http://www.iinj.org/ (Programs, then Interpreting and Translation Services)
31. New Mexico		Associations • NMTIA: New Mexico Translators & Interpreters Assoc.	Interpreter Services/Lists • http://www.cybermesa.com/~nmtia Certification (Court only)

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
32. New York		Associations • MAMI: Multicultural Assoc. of Medical Interpreters of Central New York • NYCT: New York Circle of Translators Organizations/Models • Center for Immigrant Health, NYU • Gouverneur Hospital • MIT: Metropolitan Interpreters and Translators, Inc. • Roberto Clemente Center (New York City) • University of Rochester, Dept. of Psychiatry	Interpreter Services/Lists • http://www.nyctranslators.org/links.html • http://www.sunyit.edu/library/html/culturedmed/culture/sites/mami.html (also has a medical interpreter bibliography) • http://www.metlang.com/CorpPages/gsarelease.html (Law enforcement interpreting) Training • http://www.med.nyu.edu/cih/language/interpretation.html
33. North Carolina	Yes	Associations • CATI: Carolina Association of Translators and Interpreters Organizations/Models • NCBR: North Carolina Bilingual Resource Group • NCOMH: North Carolina Office of Minority Health • North Carolina Migrant Health Program • North Carolina Refugee Health Program	Interpreter Services/Lists • http://www.catiweb.org/catisocial.htm • http://www.hhcc.arealahec.dst.nc.us/NBRG.htm • http://www.ncphca.org/program_services/migrant_health.htm Training • http://www.catiweb.org/downloads/Training Schedule. PDF (2003 Training Schedule for NCOMH • http://www.hhcc.arealahec.dst.nc.us/NBRG.htm Excellent Hispanic/Latino Resource • http://www.elpueblo.org/resources.html
34. North Dakota	Yes	• Dialog Line	Interpreter Services • http://members.tripod.com/dialog_translation/resources.html • http://members.tripod.com/dialog_translation/translation.html

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
35. Ohio		Associations • CCIO: Community and Court Interpreters of the Ohio Valley • NOTA: Northeast Ohio Translators Assoc. Organizations/Models • Interpreter Access Exchange (Central Ohio) • UHCANO: Universal Health Care Access Network of Ohio	Interpreter Services/Lists • http://www.ohiotranslators.org/ • http://www.interpreteraccess.com/ (List of partner organizations providing interpreter access to LEP individuals) • http://ccio.org/ Standards • http://ccio.org/CCIO-CodeofEthics-Community.htm UHCANO Recommendations for Statewide Model Program • http://www.uhcanohio.org/issues/language.html
36. Oklahoma		Associations • Mid-America Chapter of the American Translators Association	Interpreter Services • http://www.ata-micata.org/
37. Oregon		Organizations/Models • Centro Hispano of Southern Oregon (not on web) • Oregon Health Career Center • Oregon Health & Science University	Interpreter Services/Lists • http://www.ohsu.edu/interpreters/interpreter.html - medinterpservices • http://www.nclr.org/map/states1.asp?state=OR (Description of Centro…) • http://www.pacificinterpreters.com/ Training • http://www.ohcc.org/proghitp.html • http://www.pacificinterpreters.com/

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
38. Pennsylvania		Organizations/Models • Critical Path AIDS Project • Health Promotion Council of Southeast Pennsylvania • Health Federation of Philadelphia • Maternal & Child Health Consortium (MCHC) of Chester County	Interpreter Services/Lists • http://www.critpath.org/ --no cost interpretation/translation services to HIV/AIDS providers in the surrounding counties • http://www.choice-phila.org/CHLguide/6i0ogahe.htm (Health Fed.) • http://ccio.org/ Training • http://www.hpcpa.org/chit.html • http://www.ccmchc.org/programs.html (Scroll down to medical interpreter trng.)
39. Rhode Island		Organizations/Models • International Institute of Rhode Island • Rhode Island Hospital • SEDC: Social Economic Development Center for Southeast Asians	Interpreter Services/Lists • http://www.iiri.org/ • http://www.lifespan.org/services/socialwork/rih/interp/ • http://www.rijustice.state.ri.us/voca/VOCA/SEDC.htm Article listing other organizations working with LEP populations in the state • http://www.healthri.org/media/990727a.htm
40. South Carolina	Yes	Organizations/Models • South Carolina Hispanic Outreach's Adelante Program (Columbia) • Dept. of Social Services	Interpreter Services • http://www.state.sc.us/dss/ (interpreter resources not on website) • http://www.schispanicoutreach.org/
41. South Dakota		Organizations/Models • Planned Parenthood of Minnesota/South Dakota • Lutheran Social Services of South Dakota	Interpreter Services/Lists • http://www.ppmsd.org/medical/interpreter.asp • http://www.lsssd.org/Lutheran_Social_Services_of_So/lutheran_social_services_of_so1.html (Refugee and Immigration Services)

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
42. Tennessee	Yes	Organizations/Models • Rural Medical Services, Migrant Health Program (Cocke County) • Vanderbilt Hospital (Nashville)	Interpreter Services/Lists • http://www.ruralmedicalservices.org/ • http://ccio.org/
43. Texas		Associations • AATIA: Austin Area Translators & Interpreters Assoc. • EPITA: El Paso Translators & Interpreters Assoc. • HITA: Houston Interpreters & Translators Assoc. • MITA: Metroplex Interpreters & Translators Assoc. Organizations/Models • Casa de Proyecto Libertad (Harlington)	Interpreter Services/Lists • http://www.hitagroup.org/IT-reference-list.shtml • http://www.aatia.org/ • http://www.dfw-mita.com/
44. Utah		Associations • UTIA: Utah Translators & Interpreters Assoc. Organizations/Models • Utah Office of Ethnic Health	Interpreter Services/Lists • http://health.utah.gov/primary_care/pdfs11-00/medicalinterpretersdirectory.pdf • http://health.utah.gov/primary_care/ethnichealth.html • http://health.utah.gov/medicaid/interpreter.pdf • http://www.utia.org/ Accreditation • http://www.utia.org/
45. Vermont		Organizations/Models • Vermont Refugee Resettlement Program	Interpreter Services • http://www.healthyvermonters.info/cph/refugee/refugee.shtml

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
46. Virginia	Yes	Organizations/Models • Northern Virginia Area Health Education Center AHEC (Annandale) • Roanoke Interpreter Services (Roanoke)	Interpreter Services • http://www.ahec.vcu.edu/support.htm (AHEC) (Scroll down the page) Training • http://www.ahec.vcu.edu/support.htm (AHEC) (Scroll down the page)
47. Washington		Associations • SOMI: Society of Medical Interpreters • WITS: Washington State Court Interpreters & Translators Society Organizations/Models • CCHP: Cross Cultural Health Care Program (Seattle) • Center for Multicultural Health • Community Health Services Program (Seattle) • Community Interpretation Services Program (Seattle) • Seattle-King County Dept. of Public Health, Interpreter & Refugee Screening Program • Medical Assistance Administration, Interpreter Services	Interpreter Services/Lists • http://www.xculture.org/ (CCHP) • http://www.diversityrx.org/HTML/MOBISA.htm • http://www.diversityrx.org/HTML/MOBISB.htm • http://www.diversityrx.org/HTML/MOBISC.htm • http://fortress.wa.gov/dshs/maa/InterpreterServices/ Certification (State) • http://www.witsnet.org/ (Court only) • http://slc.leg.wa.gov/wsr/2000/07/00-06-014.htm Standards (State) • http://www.witsnet.org/ (Court only) • http://slc.leg.wa.gov/wsr/2000/07/00-06-014.htm
48. Washington DC		Associations • NCATA: National Capital Area Chapter of ATA Organizations/Models • La Clinica del Pueblo	Interpreter Services/Lists • http://www.ncata.org/ • http://www.lcdp.org/ • http://www.jobsministry.org/MedicalInterpreters/

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
49. West Virginia		Associations • Community and Court Interpreters of the Ohio Valley	Interpreter Services • http://ccio.org/
50. Wisconsin		Organizations/Models • Wisconsin United for Mental Health	Interpreter Services/Lists (Mostly Deaf/HH) • http://www.dhfs.state.wi.us/sensory/WITA/terpagencies.htm • http://www.ohrd.wisc.edu/cls/comp.htm • http://www.wimentalhealth.org/Who/culturalcompetency/index.htm
51. Wyoming		Organizations/Models • Maternal and Child Health Program • Office of Minority Health	Interpreter Services/Lists • http://www.wypca.org/Minority_Health/mh_links.html • http://wdh.state.wy.us/mch/minority.htm
52. International Organizations		• ACTI: Asociacion Cubana de Traductores e Interpretes (Cuba) • ATP: Ascociacion de Traductores Profesionales (Mexico) • CTIC: Canadian Translator & Interpreter Council • FIT: Federation Nationale des Tradecteures • OMT: Organizacion Mexicana de Traductores	Worldwide List of Organizations • http://www.deraaij.com/irt/assoc.html Global Federations • http://www.fit-ift.org/ (International Federation of 100 associations from 50 different countries) • http://www.synapse.net/~ctic/index.html (Canadian federation)

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
53. National Organizations		• ALTA: American Literary Translators Association • ATA: American Translators Association • Hablamos Juntos: A National RWJ-funded program • NAJIT: National Association of Judicial Interpreters & Translators • National Center for State Courts • National LEP Task Force • NCIHC: National Council on Interpreting in Health Care • NHeLP: National Health Law Program • SOMI: Society of Medical Interpreters • TTIG: The Translators & Interpreters Guild	Interpreter Services/Lists • http://www.atanet.org/ (Offers medical seminars around the country) • http://www.najit.org/ (Court & Legal Interpreting only) • http://www.literarytranslators.org/ (Translation only) • http://www.ncihc.org/ • http://www.sominet.org/ • http://www.hablamosjuntos.org/mission/default.asp (Website not finished but describes Interpreter Program Models) • http://www.healthlaw.org/ (Scroll down to Immigrant Health) • http://www.leptaskforce.org/The List.htm (Lists organizations that are not compliant with EO13166) • http://www.jobsministry.org/MedicalInterpreters/ (A great compilation of Medical Interpreter Websites, including training and organizations around the country) Accreditation • http://www.ttig.org/ (Nationwide Union for all specialties,) • http://www.atanet.org/ Standards • http://www.cta-web.org/ctaframeset.html (ATA Code of Ethics) Certification (Chart of All States-Court Only) • http://www.ncsconline.org/D_Research/CourtInterp.html (At some point the same thing should be done for medical interpreters)

State	English Only Laws	Examples of Already-Existing Medical Interpreter Programs and Associations	Websites
54. Regional Associations		Northeast • NETA: New England Translators Assoc. • NYCT: New York Circle of Translators Mid-Atlantic • CATI: Carolina Assoc. of Translators & Interpreters • DVTA: Delaware Valley Translators Assoc. • NCATA: National Capital Area Chapter of ATA Middle America/ Midwest • MICATA: Mid-America Chapter of ATA • UMTIA: Upper Midwest Translators & Interpreters Assoc. Northwest/Pacific • NOTIS: Northwest Translators & Interpreters Society	Northeast • http://www.netaweb.org/ (Referrals/Member Lists) • http://www.nyctranslators.org/ (Referrals/Member Lists) Mid-Atlantic • http://www.catiweb.org/ (Referrals/Member Lists) • http://www.ncata.org/ (Referral/Member Lists) • http://www.fortunecity.de/lindenpark/kuenstler/59/dvta.htm (DVTA, Referral/Membership Lists) Middle America/Midwest • http://www.ata-micata.org/ (Referral/Membership Lists) Northwest/Pacific • http://www.notisnet.org/ (Referral/Membership Lists)

Appendix B: Glossary of Interpreter-related Terms

(Source of Most Definitions: Downing, Bruce T. Professional Interpretation: Insuring Access for Refugee and Immigrant Patients. 1992)

Ad Hoc Interpreter:
An Ad Hoc Interpreter is a bilingual staff person who is called away from his/her regular responsibilities to interpret as needed.

Bilingual:
A person who is able to communicate (with varying degrees of proficiency) in two languages; some bilinguals are proficient in both languages, other bilinguals may have minimum ability in one of the languages.

Bilingual Paraprofessional:
This label has been used in the field of refugee health for an individual with competence as a health care paraprofessional who in addition is proficient (to some degree) in English and one or more other languages spoken by clients. Such people are able to provide health care services directly in the patient's language; in addition, they are often called upon to do ad hoc interpreting (see below) for other service providers.

Certified Interpreter:
A professional interpreter who is certified as competent by a professional organization or government agency through rigorous criterion-referenced testing.

Community Interpreting:
Interpreting in community settings in which individuals who do not speak English interact with government officials, police, employment counselors, school personnel, social workers, and health care personnel who do not speak their language.

Conference Interpreting:
Interpreting in diplomatic situations, negotiations (trade,military) and symposia, especially for one-way communication (a single speaker addressing an audience).

Consecutive Interpretation:
Interpreting in which the interpreter produces the target language text after the speaker has uttered a sentence or a few sentences, usually constituting one turn in the conversation; the interpreter speaks shortly after the original speaker stops.

Court Interpreting:
Interpreting for courtroom communications among the defendant, attorneys, witnesses, and judge.

Interpretation:
The conversion of an oral message from one language (the source language) into oral form in another language (the target language).

Interpreter:
A person who interprets the speech of others into another language, especially one skilled in interpretation.

Lay interpreter:
A lay interpreter is an untrained person who is called upon to interpret, such as a refugee child interpreting for her parents.

Neutrality:
Interpreters are to maintain an appearance of impartiality at all times, refraining from engaging in unnecessary conversation with any of the parties and avoiding facial expressions or postures that would suggest bias. He/she must disclose any real or apparent conflict of interest.

(Source: Mikkelson, Holly. "Towards a Redefinition of the Role of the Court Interpreter." Web:http://www.acebo.com/papers/rolinterp.htm)

Professional Interpreter:
An individual with appropriate training and experience that demonstrates the linguistic and cultural competence to interpret accurately and that understands and adheres to a code of professional ethics.

Register:
A variety of a language or a level of usage, specifically in terms of degree of formality, choice of vocabulary and pronunciation, and related to the social role of the user and appropriate to a particular need or context.

Simultaneous Interpretation:
Interpreting in which the interpreter produces the target language text while the speaker is continuing to talk; the interpreter may lag a few seconds to many seconds behind the speaker in order to understand the message as fully as possible before interpreting.

Source Language:
The language you are interpreting from.

Target Language:
The language your are interpreting into.

Translation:
The conversion of a static (often times written) source-language message into written form in the target language.

Translator:
A person who translates written documents from one language into another, especially one skilled in translation. *(The terms linguist and translator are sometimes used by laypersons for both translators and interpreters. This usage should be avoided because it leads to confusion between interpreters and translators, and between both of these and people who work in the academic field of linguistics, the scientific study of human language, who are also called linguists.)*