

THE EVOLUTION OF MEDICAL INTERPRETING

America has always been a land of many languages. Before European contact, thousands of languages were spoken by various people in North, Central and South America. European contact brought a host of new languages, creating a multilingual tapestry that is our heritage even today. Many North Americans do not know that although English is the *lingua franca* of this country, the United States has no official national language.

Immigration to the U.S. increased throughout the 1800s, fueled by economic opportunity, then dropped off during the mid-1900s, due to two World Wars, picking up again throughout the latter half of the century.

How did these linguistically diverse people overcome the barriers of language to access public services, including health care? In the early years, immigrant communities tended to settle together, forming linguistic enclaves where services were provided in their native language by their own countrymen.

As health care became more centralized and more scientifically based, however, limited English proficient patients turned more and more to healthcare providers, clinics and hospitals where English was the exclusive language of care. Some clinics, serving specific populations such as Mexican migrants, hired bilingual staff to serve as untrained interpreters. For most people, friends, and neighbors who spoke “a little English” and children who were learning the language at school became the default interpreters. Language was seen as problem for the patient to solve.

Then came the war in Viet Nam. In 1975, Saigon fell, and the world witnessed the first of many modern refugee crises. The Refugee Act of 1980 opened the U.S. door to a flood of Southeast Asian refugees, speaking Cambodian, Lao, Vietnamese, Hmong, Mien – languages rarely heard in this country before. The healthcare system was completely unprepared to address the needs of these diverse patients, many of whom had significant physical and mental health needs. And there were no welcoming ethnic enclaves, with previous immigrants who had already learned English, to step into the interpreter role. Linguistic and cultural barriers became a major cause of lack of access to health care.

Prior to 1980, interpreters provided by the healthcare system were exceedingly rare. The influx of Southeast Asian refugees, however, pushed the system to adjust. Some systems began to train bilingual individuals as medical assistants or receptionists, pulling them to interpret when necessary. But when patients were referred on to specialty care or to another clinic, linguistic barriers again frustrated the access to care.

In the late 1980s, advocates began turning to the legal system to force healthcare providers to provide language access to their limited English proficient (LEP) patients. Below, we’ll begin reviewing the legal underpinning of language access, and further on we’ll review the most relevant developments in the medical interpreting field.

THE LEGAL FRAMEWORK FOR LANGUAGE ACCESS

Title VI

In 1964, Title VI of the Civil Rights Act was enacted. Title VI is a federal law that prohibits discrimination on the basis of race, color, and national origin in programs and activities that receive financial assistance from the federal government.

In 1974, a group of students of Chinese ancestry who didn't speak English brought a class action suit (*Lau vs. Nichols*) against their school, alleging that they were denied meaningful opportunity to participate in its activities, and thus it violated Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on national origin. The U.S. Supreme Court ruled in favor of the students stating that language shall be considered an aspect of national origin because language is closely intertwined with a person's country of origin.

In the 1980s, immigrant and refugee advocates across the country began to turn to the Office for Civil Rights for relief under the 1964 Civil Rights Act. They argued that any healthcare institution that receives government funds is obliged to provide language access to limited English proficient patients and their families. Language access includes bilingual providers, interpreter services, translation services and other services that allow LEP families access to health care in the same way English-speaking families do. After a number of costly and high-profile settlements, the Office for Civil Rights (OCR) began to issue guidance to recipients of federal funding outlining their responsibilities to provide language access free of charge, culminating in a 2002 Memorandum of Guidance that stands today.¹

Title VI of the 1964 Civil Rights Act remains today the legal basis for the language access movement in the United States. In many cities, civil rights complaints were the initial lever that started the language access ball rolling. Other developments, however, have also played a role in advancing this field.

Executive Order 13166

It's interesting that the 1964 Civil Rights Act applied to programs receiving federal funding, but not to the federal government itself. In fact, aside from the Department of Health and Human Services, most departments of the U.S. government neither provided language access to their own services, nor required recipients of their funding to do so. In order to remedy this, in the year 2000, President Clinton signed Executive Order 13166, which extended language access requirements to departments of the federal government, such as the Department of Education, the Department of Labor, etc. Each was required to develop its own plan for providing language services to people being served by its programs, whether offered directly by the Department or paid for with departmental funds.

¹ Federal Register / Vol. 67, No. 75 / Thursday, April 18, 2002 / Notices. Pg. 19237.

National Standards for Culturally and Linguistically Appropriate Services (CLAS)

Also in 2000, the U.S. Department of Health and Human Services (DHHS), Office of Minority Health published the first National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards).

The National CLAS standards were developed to provide guidance to healthcare organizations on how to develop strategies that would help improve the quality of health care to the culturally diverse population in the country. While the CLAS Standards did not carry the weight of law, they presented a unifying example of what was expected of the country's healthcare providers.

In 2010, the Office of Minority Health initiated an update of the standards in consideration of all the changes and developments in the last 10 years. According to DHHS, the primary objective for this revision was to “aim to reach a broader audience, in an effort to ensure that every individual has the opportunity to receive culturally and linguistically appropriate health care and services.” The enhanced National CLAS standards were published in April 2013.

The enhanced National CLAS Standards are organized into one Principal Standard and three themes:

- Theme 1: Governance, Leadership and Workforce
- Theme 2: Communication and Language Assistance
- Theme 3: Engagement, Continuous Improvement and Accountability

As it pertains to us, interpreters in health care, the most relevant standards to review are the *Communication and Language Assistance Standards (5-8)*.

Below you can find the National Standards as published by the Department of Health and Human Services (DHHS), Office of Minority Health:

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and healthcare organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: www.thinkculturalhealth.hhs.gov

In addition, many states and cities have passed specific legislation that supports language access for LEP individuals.

Furthermore, credentialing agencies such as the Joint Commission and the National Committee of Quality Assurance are increasingly recognizing language services as an important component of quality health care.

DEVELOPMENTS IN HEALTHCARE INTERPRETING

At the same time that advocates were using legal means to push healthcare providers to provide language access, a movement was growing to build healthcare interpreting into a profession that could guarantee the quality of the interpreting being provided. This process included the development of ethics, standards of practice, training programs, standards for training programs, and ultimately, certification. Far from developing in a linear way, these advances have taken the form of disparate initiatives that have grown, coalesced, separated and rejoined over the course of years and in many geographic areas.

The Development of the National Code of Ethics and Standards of Practice

In 1987, the Massachusetts Medical Interpreters Association (MMIA) developed the first Code of Ethics for medical interpreters, discussed and applied only within its own ranks. Eight years later, in 1995, the organization published the first Standards of Practice after vetting it with colleagues at the first Critical Link International Conference on Community Interpreting held outside of Toronto. In 2012, The Massachusetts Medical Interpretation Association (MMIA) changed its name to **International Medical Interpreters Association (IMIA)**.

In 2000, **The California Healthcare Interpreting Association (CHIA)** began to write its own Code of Ethics, which was published in 2002.

The National Council on Interpreting in Health Care (NCIHC) saw that, in order to avoid each state developing its own ethics and standards, there was a need for a national process to which working medical interpreters in every state would be able to contribute. With funding first from the DHHS Office of Minority Health and then The California Endowment, the Council established a nationwide initiative to craft a single Code of Ethics and then Standards of Practice that would serve all healthcare interpreters.

Representatives from CHIA and MMIA participated in this effort. In July 2004, after two years of arduous research, the National Code of Ethics was published. One year later, in September 2005, the National Standards of Practice were issued.

Why did the NCIHC undertake the laborious task of developing a national Code of Ethics and Standards of Practice for healthcare interpreters? Besides the reason mentioned above, it would be helpful for us to get acquainted with the National Council on Interpreting in Health Care and understand their role in the field.

The National Council on Interpreting in Health Care (NCIHC) is a multidisciplinary organization whose mission is to promote and enhance language access in health care in the United States. As such, the NCIHC is not an interpreters' association; it is a national association of interpreters, administrators, trainers, researchers, healthcare providers and advocates who are all working together to move the field of language access forward.

The NCIHC started as an informal working group in 1994 and met yearly until the participants in the 1998 annual meeting decided that the working group incorporate as a formal organization. Since then, the NCIHC has worked to clarify the role of interpreters in healthcare, to develop a National Code of Ethics based on that role, National Standards of Practice based on the Code of Ethics, and National Standards for Healthcare Interpreter Training Programs based on the Standards of Practice.

Additionally, the NCIHC has produced many other papers and resources that have been pivotal in the development of health interpreting as a unique profession, such as the Sight Translation and Written Translation Guidelines and the Guide to Interpreter Positioning. Further on we will provide you with the direct link to their publications and to other relevant websites.

The Road to Certification

While limited-English-proficient patients have the legal right to meaningful access to health care through the provision of interpreters, there are no federal standards regulating the skills and qualifications of a person who provides interpreting services. As a consequence, healthcare institutions and states have struggled to create their own standards. Washington State established certification for social service interpreters in 1992, following a lawsuit and subsequent consent decree, and certification for healthcare interpreters was established two years later. California certified “medical interpreters” for a while, but this test was designed more for interpreters in workers’ compensation cases than for clinical interpreters and was eventually phased out.

As early as 2001, while the NCIHC was still working on the National Code of Ethics and Standards of Practice, the MMIA pilot its own certification test for medical interpreters in Boston. The next year, the NCIHC procured funding from the DHHS Office of Minority Health for the MMIA to work with CHIA in doing a larger pilot in both Massachusetts and California. While much was learned from these two pilot programs, there was neither funding nor the appropriate conditions for such a test to grow at that time.

Then, in spring of 2007, Language Line Services (the telephonic interpreting company) moved to launch its own internal certification program as a national certification for medical interpreters. Concerned that a commercial entity was an inappropriate certifying body, the National Council on Interpreting in Health Care convinced LLS to join with a broad range of stakeholders and organizations who were committed to working on a national certification to form the National Coalition on Health Care Interpreter Certification (NCC). Among the participant in these coalitions were the American Translation Association (ATA), CHIA, IMIA, and NCIHC.

Work in the coalition proceeded more slowly that LLS wished. In January 2009, the company decided to join forces with the International Medical Interpreter Association (IMIA) to create the National Board for Certified Medical Interpreters (NBCMI). The NCC closed down.

In July 2009, thirteen of the NCC's original members founded the Certification Commission for Healthcare Interpreters (CCHI), and on September 15, 2009, CCHI was launched. NBCMI began certifying interpreters in December 2009, and CCHI certified its first candidate about a year later.

Both certifications have been gaining more and more recognition across the United States and even abroad. They both have set minimum requirements for interpreter candidates who wish to take their certification exams, so that candidates will have a good chance of passing these validated tests. A clear understanding of the National Code of Ethics and Standards of Practice is a major component of their certification evaluation.

Conclusion

Despite the progress made since the enactment of Title VI, there remains a persistent lack of cultural and linguistic awareness in the U.S. healthcare system. The legal right of LEP patients to linguistically and culturally appropriate services is still not fully respected in many healthcare settings.

Nevertheless, as the profession of healthcare interpreting evolves, the healthcare system increasingly recognizes the critical role that a qualified interpreter plays in a healthcare encounter. The National Code of Ethics, Standards of Practice, Standards for Training Programs and the national certification programs have contributed to establishing the professional medical interpreter as a full member of the healthcare team, essential to the delivery of quality health care to limited English proficient patients.