



MEDICAL INTERPRETERS CAN SAVE MONEY, LIVES

Certification Remains Unresolved

BY SUSAN C. THOMSON, M.A., M.B.A.

Messages can get mixed between doctors and patients when they speak the same language. Consider the disastrous possibilities when they don't. Afghanistan-born Mohammad Kochi spoke little English. When he was diagnosed with gastric cancer, family members serving as his medical go-betweens softened the blow, sparing him the C-word. After his surgery, his oncologist failed to get across to either the patient or his relatives the why and how of follow-up chemotherapy. After turning it down for months, they relented when it was too late for the treatment to be of much help. Kochi died a year after his diagnosis.

A documentary video tells this real and cautionary story to teach health professionals about communicating — and miscommunicating — with patients of limited English proficiency. As one of Kochi's daughters seems to suggest in the video, everyone involved in the case might have benefited from the services of a third-party interpreter — someone fluent in not just the doctor's English and Kochi's native tongue, but also conversant with the relevant medical terms in both languages.

Such a job description fits medical or health care interpreter, an occupation that has grown in importance, prestige and numbers as the United States has steadily become more ethnically and linguistically diverse. The 2000 Census found 18 percent of Americans over age 5 spoke a language other than English at home, up from 14 percent in 1990.

For health care organizations, medical interpretation isn't an optional frill. It's the law, embedded in Title VI of the Civil Rights Act of 1964, which says organizations that get federal funds

must not discriminate on the basis of race, color or national origin. An executive order signed by President Bill Clinton in 2000, together with later guidance from the Department of Health and Human Services, made clear that language is a function of national origin and that, as recipients of federal funds, health care providers must make interpreters available for patients with limited English proficiency.

As recently as the mid-1980s very few hospitals had medical interpreters on their staffs, said Isabel S. Arocha, president of the Boston-based International Medical Interpreters Association, the profession's trade association which grew out of Massachusetts Medical Interpreters Association, founded in 1986. The international association claims 2,000 members, the vast majority of them interpreters, but also including some non-voting health care providers and other interested parties.

Lacking medical interpreters, hospitals commonly turned to what are now disparaged as "ad hoc" interpreters — patients' relatives, as in the Kochi case, or friends, or any bilingual staff mem-

bers who could be pressed into service.

That ad-hoc practice is slowly giving way as, with time and increasing awareness of the law and the need, more hospitals are hiring, on either staff or contract, specialists to facilitate medical conversations between health care professionals and patients with limited English skills.

The hospitals are also seeing to it that their interpreters have specialized training in languages and interpreting skills.

Mercy Medical Center of Des Moines, Iowa, now with 900 beds in four locations around its area, mirrors this evolution.

Nine years ago, the hospital hired Spanish-fluent David Fett-Jones to be its first staff interpreter and to assess what other interpreting services were needed. "It was literally me in a little, tiny broom closet with a folding chair," he recalled.

Today, Fett-Jones heads a staff of 22 full- and part-time interpreters of Spanish, Bosnian, Arabic and American Sign Language. "We provide extensive and continuous training for them," he said. "We work on their interpreting skills and methods, their linguistic skills both in English and their second language, their health care terminology and their general health care knowledge."

Each also writes a plan every year for continuing education to keep those skills current.

However, even a trained staff can stretch only so far, covering only so many contingencies. What, for instance, are Fett-Jones' people to do when an Arabic-speaking patient arrives, hemorrhaging, in the emergency room, and no Arabic interpreter is immediately available? Or when someone speaking a language not represented on staff needs to understand an upcoming medical procedure or details about the medicines she has been prescribed?

Increasingly, hospitals are turning for backup to companies that provide interpreting services by phone. There are several of them, the largest offering to health care and other organizations

immediate service in more than 170 languages, including exotic ones like the Guatemalan Kanjobal language and Oriya, spoken in India. Some call-in interpreting centers also offer video hook-ups.

In Miami, 536-bed Mercy Hospital recently signed up. "I think the ideal way is to have a trained interpreter in person," said Tihesha L. Wilson, MD, a staff breast surgeon with offices in the hospital's building. Still, she had phones to the new interpreting service installed in all of her examining rooms and uses them "pretty much every day" when she's seeing patients, many of them Spanish-speaking. "Even if they tend to understand what I'm saying, I want to make sure the nuances of the conversation are understood," an especially important consideration "when you're talking about cancer," she said.

She explained how the phone-in system works: After getting the patient's permission, she places the call. She tells the person answering who she is and what she needs, and is quickly put through to an interpreter. She introduces herself and her patient, then speaks to the patient as she normally would but, for the interpreter's sake, in shorter intervals. Charges for medical interpretation services are definitely worth it, Wilson said, rather than compromising communication with a patient.

Lourdes Medical Center in Willingboro, N.J., near Philadelphia, uses a telephone service at \$1.80 a minute and interpreters available from a local company at \$70 to \$90 an hour. Sr. Marge Sullivan, OSF, vice president for mission and community outreach at the 160-bed hospital, calculated that it spends between \$30,000 and \$40,000 a year on interpreting services.

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SR. MARGE SULLIVAN, OSF

Of that total, mental health patients account for some of the steepest individual interpreting charges — anywhere from \$2,000 to \$9,000 each, Sr. Sullivan said — because of the kind of treatment they require. For example, a patient needing mental health services might stay in the hospital for as many as 10 days and participate in one or two two-hour group sessions daily, Sr. Sullivan said. As an example only "slightly unusual," she told of a patient who required a hired Portuguese interpreter at a total cost of \$9,700. "That person





CERTIFYING TESTS FOR MEDICAL INTERPRETERS

Any bilingual person can claim to be — and possibly get a job as — a medical interpreter. There is no one credential that places a seal on competence, though within the field there has been general agreement for years that there needed to be some sort of national certification.

In 1994, medical interpreters along with other interested parties, including representatives of hospitals, health systems and governments, began meeting informally to talk about certification and other ways of advancing the field. Three years later the group became official, naming itself the National Council for Interpreting in Health Care. However, after agreeing on a national code of ethics and national standards of practice for medical interpreters, members of the Washington, D.C.-based organization had a falling-out in 2009 over the issue of certification.

The upshot is that there are about to be two competing national certification tests. The first one, offered since December, comes with the endorsement of the Boston-based International Medical Interpreters Association. The group's president, Izabel S. Arocha, said the test consists of a written part in English and an oral part in Spanish that is now being developed in 22 other languages.



Both parts are proctored, computer-based and offered at various testing sites around the country to anyone, not just association members, at a total cost of \$430.

So far, said Arocha, 150 interpreters have passed the test, with several hundred more likely to do so by the end of the year. Their certifications will be good for five years and renewable afterwards, provided the certificate holder has completed a certain number of continuing education credits.

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The association developed the test in conjunction with a unit of the for-profit Language Line Services, of Monterey, Calif., which describes itself as “the nation's leading over-the-phone interpretation provider” and counts many hospitals among its clients.

Concern over the company's role in creating the test prompted formation in September 2009 of the rival Certification Commission for Healthcare Interpreters (CCHI), which is readying its own “vendor-neutral” test for taking as early as this fall.

The commission's 13-member board and two advisory committees, with 20 members between them, include representatives of the interpreter industry and health care organizations and providers. Mara Youdelman, a senior attorney with the advocacy National Health Law Program, serves as the group's part-time executive director.

“CCHI strongly believes that any certification test in a high-stakes field such as health care interpreting should be developed, and not just administered, by a non-profit organization without any

potential conflict of interest or profit motive,” she wrote in an e-mail.

Arocha said the association's test-making was open to all who wanted to help, although the commission restricted for-profit companies from taking part in creating its test. There is no telling yet which, if either, test could become a national standard.

“I think [certification] is very important,” said David Fett-Jones, director of interpretation services at Mercy Medical Center in Des Moines, Iowa. However, he added, “We're probably a few years away from everyone buying into the concept,” let alone agreeing on one test over the other. For now, he welcomes the competition — “always healthy,” he said.

Separately, a handful of states have moved on their own to standardize the profession to some extent. In 1995 Washington became the first — and is, so far, the only — state to offer its own certification test, which it requires for interpreters working with Medicaid patients served by its Department of Social and Health Services. Iowa, Indiana, Texas and Oregon have passed laws requiring state certification standards for medical interpreters but, Arocha reported, have not yet set them.

So far, no states license medical interpreters as they do other professionals from accountants to veterinarians and, in some cases, sign-language interpreters. “We foresee this occurring with spoken-language interpreters as well in the future,” Arocha wrote.

For more information on the organizations, see:

- www.ncihc.org
- www.healthcareinterpretercertification.org
- www.certifiedmedicalinterpreters.org

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sat in the group with that patient and interpreted what went on in the group,” she said. “Had we not had the interpreter there, the patient wouldn’t have had a clue what was going on and wouldn’t have been able to participate.”

From Sr. Sullivan’s perspective, such expenses for patients with limited English skills are ethical and moral imperatives. “As a Catholic organization, as a Catholic hospital, part of our mission statement is we serve every person with reverence and compassion, and we reverence them and we respect them by allowing them to participate in their care,” she said. “... It’s really fundamental to who we are to respect people all the time regardless of their religion or their ethnicity.”

Patients using it pay nothing for medical interpreting. Nor does the federal government, despite having mandated it. A survey done by the National Health Law Program, a public interest law firm in Washington, D.C., found that 13 states and the District of Columbia reimburse some of the cost. Otherwise, hospitals are on their own to absorb it.

Whatever the price of using health care interpreters, the price of not using them can be exponentially higher. Frequently cited in medical interpretation circles is the 1980 case of 18-year-old Willie Ramirez, who was rushed to a hospital emergency room in the Miami area after complaining of a headache and passing out at home. His Cuban-Spanish-speaking relatives said Ramirez had felt “intoxicado,” a term meaning “nauseous” to them. Assuming the word meant the same thing as “intoxicated” in English, the non-Spanish-speaking medical staff treated Ramirez for a drug overdose. His actual condition — bleeding in the brain — went undetected and untreated for more than a day. Ramirez survived but is paralyzed from the neck down. The family sued and won a \$71 million settlement from the hospital.

The tragic misunderstanding in the Ramirez case involved a “legally sensitive or risk-sensitive” conversation, as opposed to one of the many everyday exchanges of pleasantries that take place

in health care settings but need no special interpretation. The distinction comes from Edward P. Rundle, speaking not of the Ramirez case but of a rule of thumb in effect at Miami’s Mercy Hospital, where he is vice president, human resources management. For discussion of symptoms, diagnoses, prognoses, drugs, tests, surgeries — any subject where miscommunication could be hazardous to the patient’s health or the hospital’s bottom line — Mercy encourages practitioners to dial up the professional medical interpreters rather than depend on ad-hoc translation from hospital staff.

Ad-hoc interpreters may also put hospitals at risk vis-à-vis the standards of privacy for patients’ medical records and health information established by the Health Insurance Portability and Accountability Act of 1996. Sr. Sullivan sees this as a special hazard in a hospital like hers — “a community hospital in a community where everybody knows everybody.” Using professional interpreters “just keeps everybody’s health information as their own information,” she said.

And please don’t call them translators. By definition, those are people who work with texts, while interpreters work in the spoken language in real time with real people. While acknowledging the distinction, the Bureau of Labor Statistics nevertheless lumps translators and interpreters into a single category in its 2010-11 *Occupation Outlook Handbook*, where it estimates there were 50,900

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of them altogether in 2008 and that their ranks will grow at an above-average rate — to 62,000 by 2018.

How many among them might be medical interpreters is anybody’s guess. Arocha, of the interpreters association, said she has seen estimates of 15,000 to 20,000 now and, adding other health care workers who have been trained to interpret but have other primary jobs, the number could be as high as 40,000. At any rate, she said, the demand is growing faster than the supply.

A demographic, educational and economic portrait of health care interpreters emerges from the association’s third annual salary survey, re-



leased in October 2009. Of the 559 respondents, 80 percent were female, the greatest share (41.1 percent) were between the ages of 40 and 49, and 57 percent held a bachelors degree or higher. Whether working as independent contractors, on a staff or remotely, the vast majority were earning at least \$15 an hour.

But does employing a health care interpreter improve clinical care for patients who aren't proficient in English? Four physicians posed that question in an article published in 2007 in *Health Services Research*. After methodically analyzing all 47 previous studies, they concluded: "Despite some weaknesses in the literature, the findings suggest that provision of professional interpreter services can reduce disparities in care ..."¹

Warned the authors, "Without access to professional interpreters, this large and growing population will continue to suffer differentials in both health and access to quality health care."

Although too late to help Mohammad Kochi, his instructive case lives on in the video about it and the accompanying study guide, which includes questions designed to stimulate discussion among the health care practitioners watching it. Among them: Could a professional health care interpreter have changed the situation?

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NOTE

1. Leah S. Karliner, Elizabeth A. Jacobs, Alice Hm Chen and Sunita Mutha, "Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature," *Health Services Research* 42, no. 2 (April 2007).



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