

REQUIREMENTS FOR MEDICAL INTERPRETERS

- **Hospitals, health plans, clinics, nursing homes, physicians and other providers must offer “qualified interpreters” to Limited English Proficient patients.** The major problem in the language access field is that too often, providers attempt to “get by” without the use of trained interpreters when treating LEP patients. Despite a strong consensus in the academic and research communities about the quality and safety risks of using untrained bilingual staff, adult family members and friends and minor children as interpreters, even today a majority of providers throughout the U.S. continue to use untrained interpreters even when qualified interpreters are readily available in person or remotely via telephone or video remote devices.

Subpart C to Section 1557 of the ACA deals with these issues head on. Specifically, subsection 92.201 addresses meaningful access for individuals with limited English proficiency and requires providers to offer LEP patients a qualified interpreter. In the past, DHHS regulations dating back to 2003 merely required that oral interpreters be “competent.” While “competency require[d] more than self-identification as bilingual” formal certification was not required.”

Under the new draft rule, a “qualified interpreter” is defined as an interpreter who “via a remote interpreting service or an on-site appearance”:

1. adheres to generally accepted interpreter ethics principles, including client confidentiality;
2. has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and
3. is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology.

While the new regulations do not specifically, require the use of certified medical interpreters, that is clearly their implied intent since to be a qualified interpreter one must first have gone through some type of qualification process. The draft regulations underscored this point by stating that: “the fact that an individual who has above average familiarity with speaking or understanding a language other than English does not suffice to make that individual a qualified interpreter for an individual with limited English proficiency.”

- **By moving the legal standard from “competent” interpreters to “qualified” interpreters, DHHS is increasing the standard of care and legal duty owed to LEP and Deaf and Hard of Hearing patients and requiring organizations that receive federal funds to bear the financial burden of increasing the professionalism of their language access services.**
- **The final rule explicitly bans the use of minor children as medical interpreters.** Indeed, providers are not only prohibited from relying on minor children as interpreters they are also instructed not to rely on minor children to “facilitate communication” with

LEP patients. The only exception to this rule is “an emergency involving an imminent threat to the safety or welfare of an individual or the public where no qualified interpreter is immediately available.”

- **The final rule prohibits the use of adult family members and friends as medical interpreters.** However, the final regulations allow two exceptions to this general rule. First, adult family members and friends may be used as medical interpreters in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter is immediately available. (Note: since most leading national telephonic and video remote interpreting companies can make qualified interpreters available in hundreds of languages within seconds, this exception should be regarded as limited.) Second, adult family members and friends may be used as medical interpreters where the LEP person “specifically requests that the accompanying adult interpret or facilitate communication and the accompanying adult agrees to provide such assistance.” However, the rule makes plain that providers are not relieved of their legal duty to provide a qualified medical interpreter where an LEP patient elects to use an adult family member or friend since even then, “reliance on that adult [family member or friend must be] appropriate under the circumstances.”
- **The final rule severely restricts bilingual or multilingual staff without formal training in medical interpreting from serving as medical interpreters.** The final rule distinguishes between “qualified bilingual/multilingual staff” and untrained bilingual/multilingual staff. According to the final rule, only the former may be used as medical interpreters for LEP patients. Qualified bilingual/multilingual staff is defined as “a member of a [provider’s] workforce who is designated to provide oral language assistance as part of the individual’s current, assigned job responsibilities and who has **demonstrated**” [emphasis supplied] that he or she:

1. is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology, and
2. is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages

As the draft version of the regulations noted: “because the definition of a qualified interpreter includes adherence to generally accepted interpreter ethics principles, bilingual or multilingual staff who are competent to communicate directly with individuals with limited English proficiency may not satisfy a requirement to adhere to such principles.” According to the final version of the rules, bilingual staff must not only be qualified to serve as medical interpreters, they must be able to demonstrate their proficiency in doing so.