

Physician Obligation to Provide Interpreters

Physicians treating patients who have hearing impairments or who are limited in their proficiency with the English language may be responsible for providing interpreters for such patients in the medical office at no cost to the patients. These requirements often surprise physicians who note that the cost of an interpreter may exceed the amount billed to the patient for the office visit. Whether a patient is entitled to an interpreter under these requirements, or whether other means of communication will be appropriate, is heavily fact dependent. This article will briefly analyze communication requirements that apply to physicians treating hearing impaired and Limited English Proficient (LEP) persons.

Hearing Impaired Patients

The Americans with Disabilities Act (ADA) of 1990 generally prohibits discrimination on the basis of a person's disability and applies to services rendered in private physicians' offices, among other places.¹ One of the ADA's central themes is the obligation to provide reasonable accommodations so persons with disabilities can enjoy access to services offered to the same extent as persons without disabilities. The ADA has been interpreted to require physicians to provide effective means of communication to their hearing-impaired patients through auxiliary aids and services, including interpreters, notes, other written materials, and telecommunications devices.² The physician may not impose a surcharge on the hearing-impaired patient for the provision of such auxiliary aids and services.³

The ADA contains no requirement that physicians provide and/or pay for a live interpreter for each and every patient encounter. The physician should consult with the patient to determine the most appropriate auxiliary aid or service to employ. Neither the patient nor the physician should unilaterally decide upon the auxiliary aid or service to be employed without consulting with the other. While the final choice of alternatives rests with the physician, a mutual agreement between the physician and patient will render the best result.

Under the ADA, a physician is not required to provide an auxiliary aid or service (e.g., an interpreter) if it would cause the physician an undue burden or would fundamentally alter the nature of the services normally provided.⁴ An undue burden is something that involves significant difficulty or expense, although cost alone is not determinative.⁵ Apparently, it is not considered an undue burden if the cost of the auxiliary aid or service exceeds the amount the physician will receive for treating the patient. As a practical matter, it may be difficult to show that use of an interpreter would fundamentally alter the nature of the services normally provided by a physician in most cases.

When the question is which auxiliary aid or service to utilize, physicians should be mindful that the goal is effective communication under the circumstances. With routine office matters, a pen and notepad may suffice. With more complex matters, use of a qualified interpreter may be justified. Physicians may contract with interpreters from outside interpreter services, hire staff members capable of interpreting for hearing impaired patients, or utilize friends and family of the patient. A friend or family member should be used as an interpreter only when acceptable to the patient and when the person can serve in that capacity effectively. It is clear that engaging in communication with hearing-impaired patients can be accomplished in more than one way. The challenge is finding the most effective method of communicating with the patient considering all the circumstances involved.

Limited English Proficient (LEP) Patients

In August 2003, the U.S. Department of Health & Human Services (HHS) issued to physicians and other recipients of HHS funding revised Guidance regarding Title VI of the Civil Rights Act of 1964 and the prohibition against national origin discrimination affecting LEP persons.⁶ HHS intended the Guidance to be an analytical framework for physicians and other recipients of HHS funding to use when determining how best to comply with statutory and regulatory obligations to provide language services to LEP persons.

The first question most physicians ask is whether the requirements set forth in this HHS Guidance apply to them. The requirements apply to any person receiving funds from HHS, including physicians who participate in Medicare Part A, those who participate in federally funded clinical trials and certain other patient categories. Physicians enrolled only in Medicare Part B and who do not otherwise receive federal funds would not be subject to these LEP requirements.⁷

The Guidance notes that persons who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English may be LEP persons and may be eligible to receive language assistance with respect to a medical office visit.⁸ How do physicians determine the extent of their responsibilities to LEP persons? HHS suggests physicians conduct an LEP assessment of their practice, to determine: (1) How many LEP patients they are likely to see; (2) How often they are likely to see LEP patients; (3) The importance and urgency of the medical care that is typically provided to their patients; and (4) The resources available to the medical office to pay for various language assistance programs.⁹

Some physicians may see so few LEP patients in a year that a language assistance program would not be required. There is apparently no magic number of LEP patients that triggers the obligation to provide language assistance, but generally speaking, the more LEP patients a physician is likely to see, the greater the physician's obligation in this regard.

If application of the four-factor test indicates that the physician must provide interpretation services, then the physician should advise the LEP patient that he or she has the option of having an interpreter provided at no charge, or of using his or her own interpreter. According to HHS, the physician would be obligated to pay for interpretation services even if the bill for those services exceeds the amount the physician will receive for rendering medical services to the LEP patient.

Physicians may meet their obligations by employing bi-lingual staff, by contracting with interpreters to perform services either live or by telephone, by using community volunteers and by having certain vital documents (e.g., consent forms) translated into other languages. Reliance on family members or friends as interpreters at the patient's request is permitted, but generally discouraged by HHS except in cases of emergency, because it can be difficult to determine the informal interpreter's competence and the factual circumstances at issue may make it inappropriate for someone close to the patient to be involved (e.g., child abuse or sexual assault).¹⁰ Physicians generally cannot require LEP persons to use family or friends as interpreters. Translation of written documents (e.g., consent forms) from English to another language may be appropriate in certain cases as well.¹¹

With regard to LEP compliance, the first thing a physician should do is to complete the four-factor test discussed above. If the answers to that test suggest the physician would be required to develop a language-assistance plan, the next task would be for the physician to develop a workable plan that includes the following five steps recommended by HHS: (1) Set forth procedures to identify LEP persons who need language assistance; (2) Have a mechanism for identifying possible language assistance measures for an LEP patient, i.e., how staff can obtain services or respond to LEP callers; (3) Train staff; (4) Notify LEP persons of available LEP services, e.g., posting signs in the office; and (5) Monitor and update the LEP plan as necessary.¹²

It is clear from the Guidance that no one-size-fits-all strategy applies. Whether physicians have an obligation to provide language services to LEP persons and what language services would be required are highly dependent upon the facts. The language services required of a small-town solo physician where virtually none of the population speaks a language other than English would be different from a solo physician in a county that is heavily populated by immigrants who speak little or no English. Similarly, language services required to be employed by a solo family physician in a metropolitan area would likely be different from those required of a large multi-specialty clinic in the same area.

For more information on LEP requirements, see <http://www.hhs.gov/ocr/lep/> and <http://www.lep.gov/>.

¹ 28 CFR 36.104

² 28 CFR 36.303

³ 28 CFR 36.301

⁴ 28 CFR 36.303

⁵ 28 CFR 36.104

⁶ 68 Federal Register 47311 (August 8, 2003). Guidance issued in response to Executive Order 13166 of August 11, 2000.

⁷ Id. at 47313

⁸ Id.

⁹ The LEP Four-Factor Test found at 28 CFR 36.47314: (1) The number or proportion of LEP persons likely to be encountered by the medical office; (2) the frequency with which LEP persons come to the medical office for appointments; (3) the nature and importance of the medical services provided to people's lives; and (4) the resources available to the medical office.

¹⁰ Id. at 47317

¹¹ Id. at 47318

¹² Id. at 47320