

## **Providing Interpreters for Hearing Impaired and Limited English Proficient Patients**

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 deaf or hearing impaired and Limited English Proficient ("LEP") persons.

### **Deaf or Hearing Impaired Patients**

Section 504 of The Rehabilitation Act of 1973, implemented by the Department of Health and Human Services ("HHS"), applies to all physicians who receive federal financial assistance and have 15 or more employees. Section 504 requires physicians to provide free auxiliary aids and services, including interpreters, notes, other written materials, and telecommunication devices if necessary for effective communication with their deaf or hearing impaired patients (and their companions).<sup>1</sup> The requirements of Section 504 are more onerous than the ADA's requirements. Unlike the ADA, Section 504 has no "undue burden" exception. Therefore, physicians are required to provide the appropriate free auxiliary aid or service to patients and their companions even if the cost of the aid or service exceeds the payment the physician will receive for treatment.

If physicians or employees recognize or have any reason to believe a patient, relative, or companion of a patient is deaf or hearing impaired, the physician must inform the patient that appropriate auxiliary aids and services will be provided, free of charge, when necessary for effective communication. The physician must inform the deaf or hearing impaired patient that free auxiliary aids and services are available even if the patient does not request any aid.

When a patient is not deaf or hearing impaired, auxiliary aids and services still have to be provided, when necessary for effective communication, if the patient's companion is deaf or hearing impaired. HHS defines a companion as: 1) a person whom the patient indicates should communicate with the physician about the patient, participate in any treatment decision, play a role in communicating the patient's needs, condition, history or symptoms to the physician, or help the patient act on the information, advice, or instructions provided by the physician; 2) a person legally authorized to make health care decisions on behalf of the patient; or 3) another person the physician would ordinarily and regularly communicate with concerning the patient's medical condition. The physician must consult with the patient to determine the most appropriate auxiliary aid or service to use. This communication assessment should be done

during the first appointment or when the physician becomes aware that the patient or companion is deaf or hearing impaired. HHS guidelines state that the following should be considered when determining the appropriate auxiliary aid or service, if any: 1) the nature, length and importance of the communication at issue; 2) the individual's communication skills and knowledge; 3) the patient's health status or changes thereto; 4) the patient's and/or companion's preference or stated need for an interpreter; and 5) the reasonably foreseeable health care activities of the patient. With routine office matters, a pen and notepad may suffice. With more complex matters, use of a qualified interpreter may be required.

Physicians may contract with interpreters from outside interpreter services, hire staff members capable of interpreting for deaf or hearing impaired patients and companions, or utilize friends and family of the patient. However, a family member or friend may provide interpretive assistance only if the patient or companion agrees in writing to the use of that person and use of that person is appropriate under the circumstances, giving consideration to the patient's privacy issues. HHS regulations do allow for interpreting by family members and friends in time-sensitive, life-threatening or medically urgent situations. It is very important to document all discussions with patients or companions regarding auxiliary aids and services. If an auxiliary aid or service is provided, make a note in the patient's chart. Likewise, after a communication assessment is performed, and the physician determines that auxiliary aids and services are not needed for effective communication, the physician should record in the patient's chart the reasons why the auxiliary aid or service is being denied.

It is clear that engaging in communication with deaf or 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. HHS requires a lot from physicians who treat deaf or hearing impaired patients. However, physicians can comply more easily with the law by having set policy and procedures that they use consistently with each deaf or hearing impaired patient.

## **Limited English Proficient (LEP) Patients**

In August 2003, 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.<sup>ii</sup> 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.<sup>iii</sup>

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.<sup>iv</sup> How do physicians determine the extent of their responsibilities to LEP persons?

**HHS suggests physicians conduct an LEP assessment of their practice (the Four-Factor Test, to determine:**

- (1) How many LEP patients they are likely to evaluate**
- (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.<sup>v</sup>**

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).<sup>vi</sup> 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.<sup>vii</sup>

**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.<sup>viii</sup>**

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

specialty clinic in the same area. 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-

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

1 29 U.S.C. §794, et seq.

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

3 Id. at 47313

4 Id.

5 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.

6 Id. at 47317

7 Id. at 47318

8 Id. at 47320

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