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Legislation as a Backdrop for the Professionalisation and Training of the Healthcare Interpreter in the United States

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ABSTRACT

This paper presents an analysis of the state of affairs of the healthcare interpreter in the United States of America through a legislative lens. The aim of the study is to qualitatively measure the professionalisation and training of the healthcare interpreter at both a national level and with particular focus on four states, California, Texas, New York and Washington, gauging their progress and comparing different geographical locations in homogeneity. This is achieved through an in-depth analysis of the federal and state legislation on language access to services for persons with Limited English Proficiency (LEP) and its impact on healthcare interpreter professionalisation and training at both levels.

Our analysis shows that recent legislation in the United States is moving towards better treatment of the LEP population. At the national level, the United States has developed specific legislation for regulating access to language services which has prompted the inception of two professional associations, the establishment of two similar codes of ethics and the proliferation of training programmes which share a series of common traits. At the state level, and with reference to the four states analysed, specific legislation also exists to regulate access to services by people with LEP, though the state of affairs is not homogeneous. However, although the outlook of healthcare interpreters as professionals looks positive, more efforts must be done to further organise the profession.

KEYWORDS

Healthcare interpreting, United States, professionalisation, community interpreting, language access legislation.

Introduction

The United States is a perfect candidate for an examination of community interpreter practice. It has a long history of immigration and the resulting demographics make quality healthcare interpreting a necessity. In fact, there are myriad studies which treat healthcare interpreting in the US (Torres Díaz 1998, Davidson 2000, Furmanek 2004, Valero Garcés 2006, Angelelli *et al.* 2007, Chen *et al.* 2007, Hale 2010). However, few of them have focused on how legislation has influenced the professionalisation of the healthcare interpreter and the organisation of curricula at training centres.

This paper will concentrate on the influence of legislation on the professionalisation of the healthcare interpreter. To do so, we have examined the state of affairs at both a federal and state level. In this paper, we would like to propose and answer the following research questions: what federal and state legislation exists to defend access to services for persons with

Limited English Proficiency? Has legislation led to homogeneous professionalisation and training? How is healthcare interpreting training organised? Is the outlook good for further professionalisation and for a homogeneous and unique training model?

In order to answer these questions, we will focus on the legislative structure of the United States and its ramifications for lawmaking and potential diversity in healthcare interpreter standards, specifically, the concept of federalism and the nature of the United States' Constitution. In addition to this federal perspective, we also intend to carry out an analysis of the situation at state level. As there is not space to consider each state, for our purposes California, New York, and Texas have been chosen as geographically diverse states: one covering the West Coast, another in the Northeast, and the last in the South Central region. More important than their location is their status as gateways for immigration (Walters and Trevelyan 2011) in that they have the largest shares of the nearly 40 million foreign-born people in the United States. Thus, immigration is the quantifiable factor we have elected to use to guide us in choosing the states to examine, because it is a generally dependable marker of the much less easily quantifiable Limited English Proficiency (LEP) population — the term used by the United States government for those in need of language services. In fact, previous studies have supported this assertion (Mikkelsen 1996; Torres Díaz 1998; Davidson 2000; Valero Garcés and Taibi 2004; Valero Garcés 2006; St. Germaine-McDaniel 2010). Therefore, these three states should provide a sufficiently broad panorama of the healthcare interpreter's situation in the regions where they are most needed.

Washington State is also included in this study as it is so widely referred to in the literature (Mikkelsen 1996; Torres Díaz 1998; Valero Garcés 2006; Diaz 2010). It has an extended history of regulating the profession of healthcare interpreter and it was the first state in the country to certify healthcare interpreters working for the Department of Health (NBCMI 2012). By including the state of Washington, we may also observe the effect of time on this sociological process.

1. United States governmental structure

In order to examine any of the individual states, one must first be familiar with both the governmental structure and constitution of the United States as a whole, especially if legislation, regulations, or norms are involved. These elements will dictate the scope of any such analysis, including the present article. To be more specific, it is the federalist nature of the United States' government and the open, interpretive aspect of its constitution that must be understood before attempting to enter into a study.

The United States of America is a constitution-based federal republic. The phrase ‘federal republic’ means that all three branches — executive, judicial, and legislative — can be found at both a federal or national level as well as a state level; the government is divided into multiple, semi-independent layers. This is worth highlighting because amongst its various ramifications is the possibility for states to have different policies to the national government if they disagree on an issue, or wish to provide a different nuance or scale (Rubin 2001). It is put most aptly, and certainly most famously, by former Associate Justice of the United States Supreme Court Louis Brandeis: “[...] a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country” (Althouse 2004: 1750–1751). That is, legislative discrepancy is inherent in the United States. We must not assume that federal regulations will be the only policies applicable in our analysis, nor that every state will be the same.

With this basic understanding of federalism, we may move on to briefly treat the open, interpretive nature of the United States Constitution, which is often referred to as a ‘living Constitution’ (Balkin 2005). This means, ultimately, that the Constitution is a document open to interpretation and change, so designed to allow for adaptation to a shifting world. We must derive more specific legal principles from these documents; precedence and case law elucidate this evolution (Ackerman 2007). The Constitution and other landmark documents that form the underpinnings of American legislation and regulation are inherently ambiguous and the way they are written reflects this (Beard 1936).

The elaboration of rights and privileges not stated explicitly in the Constitution, or other formational documents, can be referred to as an ‘emanation’ or a ‘penumbra’, i.e., when a provision casts a half-shadow that infers an underlying right. If this underlying right appears as an inference in multiple situations, the half-shadows act in an additive manner, until the layers take shape and can be arguably instated as a policy or right in and of itself (Kauper 1965). We mention this because the right to language services, and therefore the *raison d’être* of healthcare interpreters, is just such an emanation.

2. Alliance with the State

2.1 Federal level

Language access, and therefore the need for interpreters, is governed at a federal level through two main documents: *Title VI of the Civil Rights Act*

§601, 42 U.S.C. § 2000d (1964), and *Executive Order 13166* (Clinton 2000). Approaching them chronologically, we shall begin with Title VI, which reads as follows:

Sec. 2000d. Prohibition against exclusion from participation in, denial of benefits of, and discrimination under federally assisted programs on ground of race, colour, or national origin: No person in the United States shall, on the ground of race, colour, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Until the year 2000, with the emission of Executive Order 13166, this clause was the only provision for language access for U.S. 'residents'; the legislation does *not* say citizen. But due to the nature of the legislative structure of the United States, as discussed previously, this is all that is necessary to establish equitable linguistic access.

Language services in health care settings, including the right to an interpreter, *emanate* from the provision of protection of access, regardless of "national origin," to "any program or activity receiving federal financial assistance." National origin casts the penumbra of a distinct linguistic background, and the overwhelming majority of health care centres receive federal funding in some form or another (HHS 2003, St. Germaine-McDaniel 2010). This is not to say that after 1964, all hospitals immediately put comprehensive language access in place and began contracting qualified interpreters to protect the civil rights of their immigrant populations; quite the opposite, especially since this language service had to be provided free of charge, at the expense of the hospital. Many hospitals and health care centres in the United States set up language access services and hired interpreters or interpreting agencies only in reaction to legal complaints filed after gross medical errors or mistreatment of patients, and many such lawsuits continue to this day (Puebla Fortier 1997, Office of the Attorney General 2003a, OCR 2012). But they did provide a legal provision for subsequent cases to draw on and led to improved care. Thus, at the very least, they opened the door to a discussion of the importance of the occupation of healthcare interpreter.

In 2000, in order to update and elaborate on this provision of Title VI, President Clinton set into force E. O. 13166: "Improving Access to Services for Persons with Limited English Proficiency." The Order reiterated the rights granted by Title VI and set concrete goals to improve access of the LEP population to all government-funded programs and services. It also directed the Department of Justice to provide guidance to all federal agencies on how to bring about compliance through LEP guidance documents of their own in turn. This Order brought about a shift from a latent right protected in general

terms to a defined gap to be covered. With the publication of E.O. 13166, language access was no longer an emanation, but an explicitly highlighted responsibility enforced by the Department of Justice.

Governmental activity in the United States is not instantaneous, so it was not until 2003 that the Department of Health and Human Services (HHS) published their own particular LEP guidance document in the Federal Register: "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (HHS 2003). It is in this document that actual suggestions for practice and potential consequences for insufficient service appear, in surprising detail. The HHS lists who is bound to provide language services, the level of service that is acceptable for different sized organisations, how to measure an LEP population and its needs and what components should make up a comprehensive language services plan.

The reason this document is so important in gauging the stage of professionalisation of the healthcare interpreter relates to one of the obstacles in professionalisation: a widespread lack of understanding, wilful or otherwise, of the agenda, purpose, or definition of a particular occupation or profession (Edinger 1968; Mikkelsen 1996). Community interpreters have often suffered in this way. Many members of the public do not distinguish between translation and interpretation, or do not understand the cognitive process — and inherent challenges — that interpretation entails (Gentile 1997; Furmanek 2004; Hale 2010). However, this lack of understanding is thankfully not in evidence in the HHS guidance; reading through the entire document elicits strong evidence that interpreters and translators have had a voice in its construction.

While the definition of interpreting includes the mention of 'translating', it is still reasonably accurate, and effectively separates the two processes. In fact, the HHS does so explicitly further on, stating that "the skill of translating is very different from the skill of interpreting; a person who is a competent interpreter may or may not be competent to translate" (2003: 47316). And so the interpreter is established as a skilled, competent individual. In fact, the HHS advises that "the use of certified interpreters is strongly encouraged" (2003: 47316).

In 2013, the HHS followed its own strictures and released its Language Access plan to the public, clarifying and expanding the guidance provided by the 2003 document. Besides benefiting from the passage of the 2010 Plain Writing Act, it is obvious that the HHS has consulted even further with translation and interpretation experts. 'Competent,' 'qualified,' 'documented proficiency,' and other key words are used liberally throughout the Plan,

acknowledging that healthcare interpreting is not to be undertaken by just anyone. In fact, according to the glossary included with the Plan, an interpreter is defined as:

[...] an individual who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages, and has the appropriate training and experience to render a message spoken or signed in one language into a second language and who abides by a code of professional ethics (2013: 21).

A more complete alliance with the state to assure the status of the profession could only be ensured with consequences for those not abiding by these regulations. The HHS stresses the fact that that federal funding for organisations that do not abide by their language access obligations — including healthcare interpreters when appropriate — will be revoked.

The HHS is not in any way offering to organise interpreters or supporting movements for national coherence in certification in either of these documents. However, they do support *some* system of qualifying and rating interpreters, encourage providers to examine the quality of service they are offering, and provide minor public education on their website through downloadable documents outlining the potential dangers of using unqualified interpreters (HHS 2013), which amounts to a tacit acceptance of the interpreter as a professional.

While the HHS does not set national standards, that does not mean that they do not exist. There is one more important aspect of the federal governments' agenda of equalising access that must be considered in this discussion of the interpreter in the United States. In this country, although most medical insurance is privatised, various government-assisted health plans exist. The most famous is Medicaid and the Children's Health Insurance Program (CHIP). Medicaid is for individuals who cannot afford the medical care they need, while CHIP is for children of other low-income families who do not qualify for Medicaid (Kaiser 2012, Medicaid 2012). These programs are jointly funded by the federal government and individual states. As of the year 2000, language services such as interpreting and translation are covered by Medicaid and CHIP (Youdelman 2007). By helping to pay for what by law must be freely offered, some budgetary pressure is lifted from healthcare practitioners, allowing them the financial flexibility to actually consider contracting qualified individuals, as most objections to language service requirements are the cost of interpreters (NHeLP 2004, New York Senate 2009, IMIA 2009, Diaz 2010). By paying for Medicaid, the federal government is targeting a not inconsiderable segment of the LEP population, for they are more likely than English proficient individuals to be eligible for Medicaid (NHeLP 2004, St. Germaine-McDaniel 2010). In California, for

example, 30% of dual eligibles — those who are both ill and poor — are LEP individuals (Scalia 2007).

The system can function through a variety of avenues. Up to a certain spending cap, states can have the federal government ‘match’ their funds; whatever the state spends, the federal government will then match, contributing a corresponding amount according to the state-established rate. Most states are eligible for a base rate of a 50% match, though it can be as high as 83%. Moreover, in 2009, President Obama signed an act increasing the lowest CHIP fund matching from 50% to 75% (Au *et al.* 2009). The providers of language services can be reimbursed on a case by case basis by the hospital, which is then reimbursed in turn by the federal government; the hospital can arrange for the language service providers to be reimbursed by the federal government and remain outside the transaction; or hospitals can lump language services into their administrative costs and receive a fixed reimbursement from the federal government, regardless of how many documents were translated or encounters interpreted during that particular time period (NHLP 2004). The decision of whether or not they want to institute such a pay partnership is entirely up to the state, but the language services must be made available, no matter what.

2.2 State level

Having analysed federal legislation, we will now describe the results of an in-depth examination of regulations and norms in the four states chosen for our study: California, New York, Texas and Washington.

2.2.1 California

California is home to the largest foreign-born population in the United States, both in terms of raw numbers and in percentage. According to the 2010 Census, out of California’s 19,378,102 individuals, 4,298,000 of these residents were foreign-born, which is 22.2% of the state population. California also represents a disproportionate 24.5% of the country’s total foreign-born population. This information should take the surprise out of the fact that in 2000, the US Census recorded 224 languages spoken in California alone (Angelelli *et al.* 2007).

The California Healthcare Interpreting Association (CHIA) has demonstrated the importance they place on an alliance with the State by inviting governmental policymakers into their membership group. This is a positive step, as California’s legislation over language access was built from a long list of piecemeal, stand-alone statutes, put together over the last two decades. Some examples include strangely specific sections of the state

health code, indicative of past lawsuits or problems. If we take this legislation at face value, California has been a forerunner of language access, starting with the Dymally-Alatorre Bilingual Services Act of 1973, which requires the hiring of bilingual staff and translation of materials into languages spoken by more than 5% of the population. But this Act shows its age in its confusion of terms: bilingual equals interpreter equals translator and its definition of who is qualified to serve is shunted to other agencies to decide (California Government Code 1973). Furthermore, when the State of California was audited on its language service provision in 2010, they found that many agencies were completely unaware of this forty-year-old act. There was no great improvement in bilingual staffing or provision of adequate multilingual materials in comparison to 1999, when the last audit took place (Manneh 2010).

However, California is striving to improve the situation in its state. The federal Department of Health and Human Services has penalised or settled with at least three large healthcare organisations in California since 2003, including a pharmaceutical company and the Los Angeles County Department of Public Social Services (OCR 2012). The legislative branch has also joined in by passing a landmark piece of legislation; indeed, a 2009 study by the Federal Agency for Healthcare Research and Quality has marked California as the state with the most comprehensive healthcare interpretation laws (Kritz 2010). Assembly Bill No. 1195, enacted in 2005, requires that continuing medical education for healthcare providers must include cultural and linguistic competency elements, which will help promulgate a body of physicians and nurses receptive to interpreters. Assembly Bill No. 800, also enacted in 2005, requires a patient's primary language to be recorded in their file, which will aid the location and contracting of an appropriate interpreter.

But the most important and fundamental shift in policy, and the one that has garnered most public attention, is SB 853, which although signed in 2003, did not take effect until 2009. This bill not only reinforces the right granted by the Civil Rights Act of 1964 of all residents to interpreting services, but requires that not only Medicaid, but all private insurance companies operating within the State of California, cover interpreting services. In a country run mostly on private insurance coverage, this bill takes a huge weight off both hospitals and LEP individuals, who previously bore the financial brunt of the cost of interpreting services (Echevarria 2009). The bill faced fierce opposition from insurance groups, who insisted that they were voluntarily working on a solution and there was no need to regulate the problem, but it did ultimately pass (SB 853 2003). SB 853 does not concern itself with who is interpreting, but the state is currently pushing for voluntary certification of healthcare interpreters and the inclusion of interpreter quality

in the accreditation of hospitals. That is to say, hospitals will have a pressing reason to provide their patients with professional interpreters (Kritz 2010).

2.2.2 New York

With 19,378,102 of its residents, or 22.2% of its population, foreign-born, New York is number two in the nation, after California. It is a traditional immigration entry point, especially for European arrivals, and many immigrants from South and Central America have formed strong communities there (Cohn 2010). Although it is falling in favour as a residence for the newest generation of immigrants, it still holds 10.8% of the national foreign-born population (Walters and Trevelyan 2011).

Before 2006, the LEP population of New York had only piecemeal protection in place reinforcing the Title VI provisions. There were many statutes that established mandatory translation of documents, or rather, the dissemination of pre-translated common documents amongst many hospitals, like application forms and emergency contraception information (NHcLP 2008b). In 2006, the State of New York responded to E.O. 13166 by passing a similar state level set of regulations that mandated appropriate language services for all LEP residents; this was incorporated into the state health code as N.Y. Comp. Code R. & Regs. Tit. 10, § 405.7(a) (7). This regulation came about in response to a long series of lawsuits brought by both federal and state agencies against various New York hospitals (Office of the Attorney General 2003a, Office of the Attorney General 2003b, Martinez *et al.* 2006).

After the state regulators firmed up their requirements for language services, they then improved the financial situation of hospitals providing such services, albeit in a more limited manner than in California. In 2009, the New York Senate passed S3740B-2009, which introduced an avenue for hospitals to be reimbursed for language services granted to Medicaid and other Medical Assistance recipients. New York is currently in negotiation with its hospital administrators and state regulators in order to decide the structure of its Medicaid/CHIP fund reimbursement schedule (Au *et al.* 2009).

2.2.3 Texas

With 10.4% of the nation's immigrants, Texas comes in third place. The foreign-born share of its population rose from 9.0% in 1990, to 13.9% in 2000, to 16.4% in 2010 according to the U.S. Census Bureau. Texas was home to 4,142,031 immigrants in 2010, which is more than the total population of Los Angeles.

The Texas Association of Healthcare Interpreters and Translators (TAHIT) has been fighting for several years to improve the lot of its LEP population and its healthcare interpreters. It began in 2007 with a pilot programme to investigate whether Texas was ready to provide Medicaid enrollees with oral and written language services. At the time, Washington and Montana were the only states to cover all Medicaid enrollees; Texas took advantage of federal Medicaid reimbursements for certain plans, but not all. The hospitals involved were interested in expanding the process, but ultimately efforts failed because the administrations involved considered the paperwork to be too cumbersome (Texas Health and Human Services Commission 2007). With this failure, TAHIT decided to concentrate on mandatory certification for healthcare interpreters.

Working together with the Austin Area Translators and Interpreters Association (AATIA), TAHIT reviewed pertinent legislation from Indiana, Oregon and Washington before basing a draft bill on Oregon's system in 2007. Though the legislation was favoured by committees reviewing the draft, it was never passed because of other legislative priorities, anti-immigration sentiment and fiscal concerns (Diaz 2010). After further refining, the inclusion of the Texas Society of Interpreters for the Deaf and harder lobbying, HB 233 was signed into law in 2009. The bill is quite unique. It establishes "an advisory committee to establish and recommend qualifications for certain healthcare translators and interpreters" (HB 233 2009).

By virtue of this bill, all healthcare interpreters in Texas must ultimately be certified to practise. However, built into the text of the bill, to be considered qualified, one must either have been trained in healthcare interpreting and received some certification or "have practical experience as an interpreter" (HB 233 2009). The committee also has a year to form, and then several years to actually decide on, the qualifications that will be required. So currently, potentially untrained interpreters can still slip in, and the process has no concrete end date, though it is also worth mentioning that the Texas Advisory Committee on Qualifications for Healthcare Translators and Interpreters has already begun submitting recommendations for the state legislature.

2.2.4 Washington

Washington State does not have one of the top five percentages of LEP populations in the country, but it is still diverse. At 6,724,540 LEP residents, or 13.2% of its population, Washington is home to 2.2% of the nation's LEP residents and is number 10 in the nation. Washington has been included in this study as a kind of outlier, as an example of the kind of laboratory

Brandeis referred to in his explanation of federalism (Althouse 2004). As a matter of fact, many studies have mentioned the long history Washington has in responding to changing legislation and mores by certifying and organising interpreters (Mikkelsen 1996; Puebla Fortier 1997; Torres Díaz 1998; Valero Garcés 2006; Diaz 2010; NBCMI 2012). As a result, Washington cannot in good conscience be left out of a discussion of the professionalisation of the healthcare interpreter, because this state has also been a trailblazer in Medicaid coverage of language services in that they are one of the only states that have covered all Medicaid enrollees.

For almost two decades now, the Washington State legislature has reflected a growing concern with cultural diversity and equal access to health care, incorporating such language into its administrative code. Washington did not develop such wording out of altruism, but in response to a wave of Title VI lawsuits (DSHS 2012). In the 1970s, Washington received a large influx of immigrants and community programs were overwhelmed. Hospitals were taking advantage of interpreters from community services, until they insisted that hospitals pay for interpretation. Negotiations between the two factions largely failed and language services in hospitals faltered almost completely. In 1981, three hospitals in Seattle received Title VI complaints from three separate clients. A few months later, these hospitals settled and agreed to institute interpreter programs. A year later, a group of 10 hospitals in Seattle agreed to contract interpreter services from an agency called Community Interpretation Services (Puebla Fortier 1997). This agency is still in operation today.

The success of these complaints opened the door and other hospitals followed suit. But more importantly for the healthcare interpreter, it also attracted the attention of the DSHS. Concerned by the number of complaints filed against them as well, and determined to address the root of the problem, in 1991 they began testing and certifying all interpreters, translators, and bilingual staff members. Over the next few years, they created the Language Testing and Certification program and revised state laws to ensure that any interpreter working for the DSHS had to be a consummate professional. The exact sections are state law RCW 41.56.030, 41.56.113, 41.04.810, 43.01.047, and 74.04.025, enacted in 1999 (DSHS 2012). Within the text of this legislation, the DSHS defines an interpreter, an authorised interpreter, a certified interpreter, a certified bilingual employee and a qualified interpreter as distinct individuals with distinct roles within the DSHS. The difference between 'certified' and 'qualified' is that a certified interpreter has sat for testing in a language offered by the DSHS; qualified interpreters have been screened for bilingual fluency and obtained certification from another source, as the DSHS does not offer certification in their language.

While the union only admits DSHS-employed interpreters, the DSHS system of certifying interpreters has had a lasting effect outside its doors. Harborview, UW Medical Centre, and Swedish, three of the largest and best hospitals in Seattle, the most populous city in Washington (Comarow 2012), require that any interpreter contracted through agencies to work with them must have DSHS certification (Harborview 2012, Swedish 2012, UW Medical Centre 2012). So even though Harborview has its own training programme for staff interpreters (Seattle Channel 2009) and there are no hiring regulations for public hospitals in state legislature (DSHS 2012), the certification is respected and enforced anyway.

3. Professional associations and codes of ethics at the federal and state level

As we can see, legislation in the US is advanced and it has contributed to the development and reinforcement of professional associations and codes of ethics at both the federal and state level. This has had an impact on the creation of professional associations such as the International Medical Interpreters Association (IMIA) and the National Council on Interpreting in Health Care (NCIHC).

The IMIA was not originally a national association. It began in 1986 as the MMIA, the Massachusetts Medical Interpreters Association, before gradually expanding throughout the country into 35 other states and 14 other countries. The NCIHC came about much more recently, in 1994, as a working group jointly operated by two Seattle, Washington interpreters associations: the Cross Cultural Health Care Program and the Society of Medical Interpreters of Seattle, coalescing as a national body in 1998, with a mission of national unity of standards and practices in healthcare interpreting. Its headquarters are in Washington, D.C.

Both the IMIA and NCIHC have firmly established codes of ethics specifically for healthcare interpreters, which include different points on confidentiality, accuracy of the message rendered, advocacy and cultural mediation when appropriate and neutrality, to name but a few.

At the state level, and focusing on the four states we have chosen, California has one of the most prestigious and well organised professional associations in the United States: the California Healthcare Interpreting Association or CHIA. Established in 1996 as the California Healthcare Interpreters Association, in 1998 they shifted focus to serving the entire community involved. The California Standards for Healthcare Interpreters are also recognised and respected nationally. They have been used as a point of

reference for both national interpreter associations and those in other states (CHIA 2002; Connell *et al.* 2005; Angelelli *et al.* 2007; TAHIT 2009; IMIA 2012). The CHIA Standards were formulated and based on medical ethics, to address common mistakes made by untrained interpreters. Advice was sought from interpreters who had worked for over three years in healthcare or healthcare-related interpreting in many languages, organised into four focus groups throughout California. After 21 drafts and 28 months of reintegrated feedback, the Standards were published and disseminated (Angelelli *et al.* 2007).

For its part, New York seems to have a plethora of healthcare interpreter professional associations: the New York Association of Medical Interpreters (NYAMI), the Association of Medical Interpreters of New York (AMINY), and the Multicultural Association of Medical Interpreters (MAMI). But unfortunately, both NYAMI and AMINY are defunct. Luckily for the healthcare interpreters of New York, MAMI is still up and running, as well as the IMIA chapter in New York. MAMI does not, however, describe itself as a professional association, but an organisation that provides and trains interpreters in both the medical and legal subfields, rather more like an agency. It was founded in 1998 and only serves Central and Upstate New York. Even if we were to continue to consider MAMI a professional association, it would not matter in terms of its code of ethics: they use the code developed by the NCIHC. The New York IMIA chapter uses the code developed by IMIA. No particular New York code of ethics or standards has been developed.

The situation in Texas is very much the same, in that it has several professional associations for interpreters, but only one that is state-wide and specifically for healthcare interpreting: the Texas Association of Healthcare Interpreters and Translators (TAHIT). As for a code of ethics, TAHIT insists in its bylaws that every member must abide by “the code of ethics” (TAHIT 2012), but TAHIT does not have its own, independently formed code; each member abides by the established code of ethics of his or her choosing, most opting for the NCIHC or IMIA codes.

Like all the other states discussed in this article, Washington has a chapter of the IMIA. There is another organisation called the Cross Cultural Health Care Program (CCHCP), established in 1992, which has a different focus: minority, refugee, and immigrant populations. The CCHCP is not a group for interpreters, but considers itself a training and consulting organisation (CCHCP 2012a, 2012b). Where Washington truly stands out, however, is with its healthcare interpreters’ union. Interpreters United, Local 1671 is a subsidiary union of the Washington Federation of State Employees and comprises the interpreters who work for the Washington State Department of

Social and Health Services (DSHS). The DSHS handles all the managed care programs for those who cannot afford fully privatised insurance, including Medicaid enrollees. They directly hire and certify their own bilingual staff, interpreters and translators, as well as being one of the premier certifying agencies of the state (DSHS 2012). For many years, the interpreters working for the DSHS were separated from their employer by a broker and an agency, both of which took a commission from the interpreter's fee. Frustrated by the lack of transparency, poor pay and lack of compensation for cancelled appointments, the interpreters working for the DSHS formed a union in 2009 (Interpreters United 2012). The union is voluntary as interpreters can still work without being a member, but membership is quickly growing, as they have negotiated an exclusive contract with the DSHS. So, a union interpreter is employed for any Medicaid-related encounter in a private hospital or any encounter in a DSHS centre, though not necessarily in other circumstances. The DSHS has actually formed its own code of ethics for its healthcare interpreters, freely available online. Developed in 1999 in conjunction with its requirements for certification, it is a 14 tenet document stressing accuracy, cultural sensitivity, confidentiality, non-discrimination, impartiality and professional development (DSHS 1999). Certain hospitals also have their own institutional codes of conduct which are quite similar, with dress code and hospital cleanliness procedures included (Swedish 2012; UW Medical Centre 2012).

4. Training in healthcare interpreting in the United States

Having described the legislative situation at both the national and state level along with professional associations and the code of ethics, we then needed to find out whether legislation had also had an impact on training, since we consider proper training to be the first step towards a more robust professionalisation. We therefore carried out a curricular analysis to find out (1) whether training centres have proliferated with these new norms and regulations at both the federal and state level; (2) how training is organised in the US; and (3) whether there is a certain homogeneity in training criteria as the basis for a formal professionalisation of the healthcare interpreter. Given that one of the most important professional associations we have dealt with is the IMIA, we will focus on the training programmes recommended by this association.

On its webpage, the IMIA includes a list of 49 university programmes in the US, 62 continuing education workshops, 110 intensive 40–70 hour programmes and 7 national certification training courses. We could say that there is no training institution operating on a truly national scale. Most are run by state universities or small private companies. With advances in online learning, there are many such institutions that offer webinars or online

courses of varying lengths and quality. The only unifying standard for healthcare interpreter training on a national level is the suggestion by the NCIHC that the course must be at least forty hours long and that it cover ethics, problem solving techniques and cross-cultural training. For its part, the IMIA suggests that a programme of education for interpreters should have a minimum of 40 hour duration with a certificate of successful completion. According to the IMIA, it is important for healthcare organisations to verify the completion of formal training in the techniques, ethics, and cross-cultural issues related to healthcare interpreting and for interpreters to be assessed for their ability to convey information accurately in both languages before they are allowed to practise. It is worth noting that there are no formal requirements, though in order to be accredited as a training centre, the IMIA checks that a programme meets specific measurable standards, after a thorough review process by auditors and a site visit.

At the national level, the states which offer a wide range of healthcare interpreting programmes are North Carolina, California, Massachusetts and Oregon. It is worth noting that most of the programmes have the language combination Spanish-English since Spanish is recognised as the second most-used language in the United States.

The majority of the 49 university programmes included in the IMIA list focus on healthcare interpreting, although they have different names, for example, 'cross cultural communication in health care', 'healthcare interpreting,' 'medical interpreting,' or 'interpreting in health and human services.' Eleven of the programmes do not specialise in healthcare interpreting training, but instead follow a more general curriculum that includes a course in healthcare interpreting. Other programmes are also general, but have a healthcare interpreting track.

To be accepted onto these programmes on healthcare interpreting, it is necessary to prove an advanced knowledge of one language other than English — Spanish in approximately 80% of the programmes —, academic proficiency in English and, for some programmes, a command of interpreting skills (see the IMIA webpage for more details on specific admission criteria).

In terms of the curricula, most of the programmes include several categories of courses: interpreting skills, professional ethics, protocols, cultural and linguistic sensitivity and medical terminology. Some programmes also include advanced courses, such as mental health, anatomy and physiology and an internship, practicum, or field experience.

5. Conclusion

Now that we have gathered the evidence and assessed the state of affairs, both at the federal and state level, we can answer the questions posed at the beginning of the paper and state that, on the one hand, the United States has specific legislation for regulating access to services by people with limited English proficiency. The US also has two important professional associations; there are two similar codes of ethics and a fledgling alliance with the state has developed that signals that the state is listening to, and working with, the healthcare interpreter community.

Regarding training, given the high number of training centres, we could say that probably this legislation has prompted the proliferation of training programmes. However, national training institutions are sparse and we can observe a lack of a homogeneous national learning model because each school adopts its own learning approach. Nevertheless there are a series of traits that almost all the schools share: most of them have admission exams which guarantee that the students who enrol in the programme have a high command of English and the other working language, normally Spanish, since this language is the most widely spoken in the United States; this guarantees language proficiency. Furthermore, training is usually based on three fundamental pillars: (1) the acquisition of interpreting techniques (generally liaison and consecutive, but seldom simultaneous); (2) the improvement and reinforcement of the working languages and (3) the command of medical terminology. Thus programmes are usually divided into content courses that initiate the student in medical concepts and the code of ethics and medical structure in the US; language courses aimed at strengthening language competencies and initiating the student in medical terminology and interpreting courses which train students in the modalities most frequently used in the medical field: liaison and consecutive interpreting. In short, training institutions try to adapt and offer the most appropriate and comprehensive training that meets the existing regulations and satisfies the market's needs.

With reference to the four states that we have analysed, we could say that specific legislation exists to regulate access to services by people with LEP. California has a very strong professional association, widespread high quality training institutions and a very solid and enforced code of ethics. The state works closely with the professional association and recent legislature regarding insurance companies underscores a governmental understanding of interpreter functions, though there is no control over entry to the profession instated in law.

New York has no strong state professional association or code of ethics *per se*, though it does have an active chapter of the national association and abides by its code. Their training programmes are good and the State of New York acknowledges that interpreters have a special skill set and are necessary to the goal of equal access to healthcare for LEP individuals. Texas has adequate training, though no code of ethics of their own; they use the high standards set by others. However, they do have a strong professional association and are working closely with the state; in the next few years they have a very real chance of attaining control over entry to the market.

Finally, Washington does not have the same kind of professional association as other states, but instead, it has a union. The union does not include all healthcare interpreters in the state, but it is highly effective within its own scope, and the standards of practice set by this group are used by hospitals as requirements for non-union interpreters. It is home to one of the most popular training programmes in the country, has a code of ethics of its own and a strong alliance with the state, since they certify its interpreters. However, control over entry is not complete and there is still widespread misunderstanding as to the role of the interpreter in the general public.

In short, the state of affairs in the United States is not homogeneous. Not every region values the role of the interpreter in the same way, nor are the associations equally powerful. In all honesty, the market for and treatment of the healthcare interpreter in the United States will probably never be homogenous, as it comprises a vast geographical area with variable LEP populations. Where there is less need for the interpreter, the occupation will probably be less professionalised.

But where there is a need, such as in the case of the states examined in this study, more time working towards professionalisation does indeed have a tenuous connection to further progress, as we see in the case of Washington versus New York. A deep alliance with the state is much more indicative of professionalisation, though this is entirely to be expected: the state does not support a weak profession, but bolsters those professions which are organised enough to prove that they are of use to the public (Hall 1968; Golembiewski 1983). That is to say that to forge a good relationship with the state, the occupation must have already proved itself to be organised, ethical and self-enforcing. Either way, the outlook of healthcare interpreters as professionals looks positive, though slow to develop. Recent legislation is moving towards better treatment of the LEP population of the United States, in spite of persistent anti-immigrant sentiment that has dogged the issue throughout the history of community interpreting (Mikkelsen 1996; Puebla Fortier 1997; Diaz 2010).

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