National Council on
Interpreting in Health Care

NCIHC

Subject: Public Comment on the Critical Importance of Language Access in Healthcare
To: United States Commission on Civil Rights
From: The National Council on Interpreting in Health Care

The National Council on Interpreting in Health Care (NCIHC) appreciates the opportunity to submit comments to the U.S. Commission on Civil Rights about the great importance of language access in healthcare settings.

NCIHC is a 501(c)3 nonprofit education and policy organization whose mission is to promote language access as a routine part of healthcare services in our country for patients and families who use a language other than English and for the healthcare professionals who care for them.

Language access in healthcare means ensuring effective communication between healthcare staff and people who don't speak English as their primary language. This requires a range of services and considerations to prevent language barriers from leading to patient harm or limiting access to quality healthcare services. Language access includes oral and signed interpretation provided by qualified interpreters, written translation by qualified translators, identification and qualification of bilingual healthcare staff, and additional auxiliary aids and services. These auxiliary aids and services may include assistive listening devices, captioning services, note takers, written materials, TTYs, videophones, qualified readers, audio recordings, Braille materials, screen readers, magnification software, large print materials, accessible information and communication technology, and other effective methods of making information accessible to people who are deaf, hard of hearing, blind, have low vision, or use a language other than English.[1]

Both translation and interpretation serve crucial but distinct functions in healthcare communication. While interpretation involves facilitating real-time spoken or signed language communication between parties speaking different languages, translation focuses on converting written text from one language to another.[2]

Many people who use languages other than English for healthcare face intersecting barriers such as limited digital literacy, economic hardship, or trauma, making the provision of language access services even more vital.[3]

As discussed during the Commission's Briefing on March 21, the right to language access is rooted in our federal civil rights laws. With at least 25 million residents who report speaking English less than very well[4] and some 12 million who report having serious difficulties with hearing,[5] language access services in spoken, written, and signed languages have never been more important to ensuring that all of us can thrive.

For more than two decades, NCIHC has worked to make sure that specialized tools needed to ensure the provision of high quality language services are freely available nationwide at www.ncihc.org. These tools include the National Standards of Practice for Interpreters in Health Care,[6] outlining the essential tenets for qualified healthcare interpreters which not only include accuracy but also cultural awareness and respect. These Standards, when used in conjunction with the National Code of Ethics for Interpreters in Health Care,[7] provide a foundational framework for ethical and equitable language support. Interpreters themselves recognize their critical role in ensuring patient safety by facilitating communication, giving patients a voice, and navigating ethical tensions,[8] often functioning as conduits, health literacy guardians, and cultural brokers within the healthcare team.[9]

Evidence Supporting Language Access Services

The need for robust language access services is quite clear, and has been very well-documented for many years. The benefits of high quality language services include:

- Increased access to appropriate healthcare services for patients with LEP[10]
- Improved patient safety and health outcomes[11,12]
- Reduced medical errors when compared to ad hoc or no interpreters[2,13,14]
- Reducing the elevated rate of adverse events experienced by patients with LEP[15,16]
- Decreased emergency department visits and hospital readmissions[17,18]
- Improved ability of patients to understand and follow treatment and discharge instructions[19,20]
- Enhanced risk management[21]

Meaningful compliance with legal mandates also results in substantial cost savings to patients, families, health systems, insurers, and government agencies.[18,22]

The many avoidable harms linked to the lack of investment in language services in healthcare contradict the core tenet of the medical profession to do no harm to persons, a tenet that is also reflected in interpreters' national code of ethics and standards of practice. These tenets are not merely aspirational, but foundational for ensuring ethical, safe, and equitable care for individuals with limited English proficiency.[23–25]

Despite the clear benefits, barriers to accessing professional interpreters persist, stemming from system-level factors like time constraints and workflow complexity,[26] leading providers to sometimes "cut corners,"[27] and from patient perspectives including lack of availability or fear.[28]

The Critical Role of Human Interpreters

We call attention to a very critical and timely issue: the ongoing need for trained human interpreters and translators in healthcare. While acknowledging the emergence of technologies

like AI-generated interpreting which can seem appealing as a "quick fix" when an interpreter is not available for a specific language or at a specific time, AI tools cannot currently replicate the highly nuanced interpersonal communication, cultural understanding, and ethical judgment provided by qualified human interpreters.[29,30] Additional concerns about AI-generated interpreting have been raised by the Stakeholders Advocating for Fair and Ethical AI in Interpreting[31] and enumerated in NCIHC's "Guidance For Healthcare Organizations Evaluating the Potential Use of AI-generated Interpreting."[32]

Studies evaluating automated translation tools like ChatGPT and Google Translate for critical healthcare communication, such as emergency department discharge instructions, have found concerning levels of inaccuracy and inconsistency.[33,34] While professional remote interpretation via video can be comparable in accuracy to in-person interpretation[14] and may offer advantages over telephone interpretation in certain contexts,[35] the complex skills of a qualified human remain paramount to facilitating effective communication.

Need for Regulation and Quality Assurance

NCIHC strongly advocates for the regulation of quality language services. Varied levels of interpreter training and qualifications across the country create inconsistencies that can jeopardize patient safety.[36] Even with professional interpreters, omissions can occur,[37] underscoring the need for consistent training and quality assurance. Some states and national bodies have developed certification programs for healthcare interpreters, such as the Certification Commission for Healthcare Interpreters (CCHI) and the National Board of Certification for Medical Interpreters (NBCMI). These models demonstrate that national qualifications are both possible and necessary. Establishing clear standards, competency requirements, and oversight mechanisms is essential to guarantee that all LEP individuals receive language assistance from competent and ethical professionals.[28,38]

Conclusion and Recommendations

As the leading national organization dedicated to promoting and enhancing language access in health care in the United States, we urge the U.S. Commission on Civil Rights to find that there is a need to prioritize and strengthen policies that ensure meaningful access for individuals with LEP. Language access is a fundamental civil right, and ensuring this right necessitates the provision of effective interpreting services.[39]

NCIHC urges the Commission to advise Congress to:

1. **Recognize the indispensable role of qualified human interpreters and translators in healthcare settings.**
2. **Prioritize policies that support comprehensive language access services.**

3. **Advocate for adequate funding to develop and maintain high-quality language access programs.**
    a. Establish clear mechanisms for reimbursement of language services in Medicare and Medicaid.
    b. Ensure Federally Qualified Health Centers receive adequate funding for language access services.
4. **Establish clear standards.**
    a. Create specific federal guidelines delineating when machine translation is appropriate and when human interpreters or translators are necessary.
    b. Require healthcare providers to implement proper safeguards when using automated translation services.
    c. Establish clear national requirements for interpreter qualifications and training.
5. **Fund research and monitoring of language access services.**
    a. Fund rigorous studies on the effective implementation of language services and the disparities faced by individuals with LEP in healthcare settings.
    b. Support data collection on health outcomes for individuals with LEP.
    c. Require consistent collection and reporting of:
        i. Language preference data in electronic medical records
        ii. Requests for language services
        iii. Provision of language services including the interpreting modality
6. **Restore and strengthen oversight infrastructure.**
    a. Reinstate the HHS Office of Minority Health and regional Offices for Civil Rights that have been closed.
    b. Provide adequate funding to federal and regional OCR offices to ensure effective monitoring and enforcement.
    c. Support the Health CARE Act to establish a universal symbol for language services availability.

Furthermore, NCIHC recommends that the Attorney General **strengthen enforcement mechanisms** by:

1. Establishing stronger enforcement mechanisms for language access requirements.
2. Investigating and addressing systematic language access violations in healthcare settings.

This is not merely a matter of convenience; it is a matter of patient safety, ethical practice, and fundamental civil rights.[40]

Sincerely,

The National Council on Interpreting in Health Care

References

1. US Department of Health and Human Services. Nondiscrimination in Health Programs and Activities. Federal Register. May 6, 2024. Accessed September 25, 2024. https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities

2. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Services Research*. 2007;42(2):727-754. doi:10.1111/j.1475-6773.2006.00629.x

3. Twersky SE, Jefferson R, Garcia-Ortiz L, Williams E, Pina C. The impact of limited English proficiency on healthcare access and outcomes in the U.S.: A scoping review. *Healthcare*. 2024;12(3):364. doi:10.3390/healthcare12030364

4. Batalova J, Zong J. The Limited English Proficient Population in the United States in 2013. migrationpolicy.org. July 7, 2015. Accessed April 13, 2025. https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-2013

5. U.S. Census Bureau. Sex by Age by Hearing Difficulty. Accessed April 14, 2025. https://data.census.gov/table/ACSDT1Y2023.B18102?q=B18102:+Sex+by+Age+by+Hearing+Difficulty

6. National Standards of Practice for Interpreters in Health Care. Published online 2005. Accessed April 14, 2025. https://ncihc.memberclicks.net/assets/z2021Images/NCIHC%20National%20Standards%20of%20Practice.pdf

7. A National Code of Ethics for Interpreters in Health Care. Published online July 2004. Accessed April 14, 2025. https://www.ncihc.org/assets/z2021Images/NCIHC%20National%20Code%20of%20Ethics.pdf

8. Wu MS, Rawal S. "It's the difference between life and death": The views of professional medical interpreters on their role in the delivery of safe care to patients with limited English proficiency. *PLOS ONE*. 2017;12(10):e0185659. doi:10.1371/journal.pone.0185659

9. Suarez NRE, Urtecho M, Jubran S, et al. The Roles of medical interpreters in intensive care unit communication: A qualitative study. *Patient Education and Counseling*. Published online October 25, 2020. doi:10.1016/j.pec.2020.10.018

10. Diamond L, Izquierdo K, Canfield D, Matsoukas K, Gany F. A Systematic Review of the Impact of Patient–Physician Non-English Language Concordance on Quality of Care and Outcomes. *Journal of General Internal Medicine*. 2019;34(8):1591-1606. doi:10.1007/s11606-019-04847-5

11. Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. *Medical care research and review : MCRR*. 2005;62(3):255-299. doi:10.1177/1077558705275416

12. Kwan M, Jeemi Z, Norman R, Dantas JAR. Professional interpreter services and the impact on hospital care outcomes: An integrative review of literature. *International Journal of Environmental Research and Public Health*. 2023;20(6):5165. doi:10.3390/ijerph20065165

13. Flores G, Abreu M, Barone CP, Bachur R, Lin H. Errors of medical interpretation and their potential clinical consequences: A comparison of professional versus ad hoc versus no interpreters. *Annals of Emergency Medicine*. 2012;60(5):545-553. doi:10.1016/j.annemergmed.2012.01.025

14. Nápoles AM, Santoyo-Olsson J, Karliner LS, Gregorich SE, Pérez-Stable EJ. Inaccurate Language Interpretation and Its Clinical Significance in the Medical Encounters of Spanish-speaking Latinos. *Medical care*. 2015;53(11):940-947. doi:10.1097/MLR.0000000000000422

15. Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *International Journal for Quality in Health Care*. 2007;19(2):60-67. doi:10.1093/INTQHC/MZL069

16. Khan A, Yin HS, Brach C, et al. Association Between Parent Comfort With English and Adverse Events Among Hospitalized Children. *JAMA Pediatrics*. Published online October 19, 2020:e203215. doi:10.1001/jamapediatrics.2020.3215

17. Lindholm M, Hargraves JL, Ferguson WJ, Reed G. Professional language interpretation and inpatient length of stay and readmission rates. *Journal of General Internal Medicine*. 2012;27(10):1294-1299. doi:10.1007/s11606-012-2041-5

18. Karliner LS, Pérez-Stable EJ, Gregorich SE. Convenient Access to Professional Interpreters in the Hospital Decreases Readmission Rates and Estimated Hospital Expenditures for Patients With Limited English Proficiency. *Medical care*. 2017;55(3):199-206. doi:10.1097/MLR.0000000000000643

19. Wilson E, Chen AH, Grumbach K, Wang F, Fernandez A. Effects of Limited English Proficiency and Physician Language on Health Care Comprehension. *Journal of General Internal Medicine*. 2005;20(9):800-806. doi:10.1111/j.1525-1497.2005.0174.x

20. Luan-Erfe BM, Erfe JM, DeCaria B, Okocha O. Limited English Proficiency and Perioperative Patient-Centered Outcomes: A Systematic Review. *Anesthesia & Analgesia*. 2023;136(6):1096. doi:10.1213/ANE.0000000000006159

21. Wasserman M, Renfrew MR, Green AR, et al. Identifying and Preventing Medical Errors in Patients With Limited English Proficiency: Key Findings and Tools for the Field. *Journal for Healthcare Quality*. 2014;36(3):5-16. doi:10.1111/jhq.12065

22. Jacobs EA, Leos GS, Rathouz PJ, Fu P. Shared Networks Of Interpreter Services, At Relatively Low Cost, Can Help Providers Serve Patients With Limited English Skills. *Health Affairs*. 2011;30(10):1930-1938. doi:10.1377/hlthaff.2011.0667

23. Diamond LC, Schenker Y, Curry L, Bradley EH, Fernandez A. Getting By: Underuse of Interpreters by Resident Physicians. *J GEN INTERN MED*. 2009;24(2):256-262. doi:10.1007/s11606-008-0875-7

24. Basu G, Costa VP, Jain P. Clinicians' obligations to use qualified medical interpreters when caring for patients with limited english proficiency. *AMA Journal of Ethics*. 2017;19(3). doi:10.1001/journalofethics.2017.19.3.ecas2-1703

25. Fernández A, Pérez-Stable EJ. ¿Doctor, habla español? Increasing the Supply and Quality of Language-Concordant Physicians for Spanish-Speaking Patients. *J GEN INTERN MED*. 2015;30(10):1394-1396. doi:10.1007/s11606-015-3436-x

26. Hsieh E. Not Just "Getting by": Factors Influencing Providers' Choice of Interpreters. *Journal of General Internal Medicine*. 2015;30(1):75-82. doi:10.1007/s11606-014-3066-8

27. Mayo R, Parker VG, Sherrill WW, et al. Cutting Corners: Provider Perceptions of Interpretation Services and Factors Related to Use of an Ad Hoc Interpreter. *Hispanic health care international : the official journal of the National Association of Hispanic Nurses*. 2016;14(2):73-80. doi:10.1177/1540415316646097

28. Brooks K, Stifani B, Batlle HR, Nunez MA, Erlich M, Diaz J. Patient Perspectives on the Need for and Barriers to Professional Medical Interpretation. *Rhode Island medical journal (2013)*. 2016;99(1):30-33.

29. Nápoles AM, Santoyo-Olsson J, Karliner LS, O'Brien H, Gregorich SE, Pérez-Stable EJ. Clinician ratings of interpreter mediated visits in underserved primary care settings with ad hoc, in-person professional, and video conferencing modes. *Journal of health care for the poor and underserved*. 2010;21(1):301-317. doi:10.1353/hpu.0.0269

30. Birkenbeuel J, Joyce H, Sahyouni R, et al. Google translate in healthcare: preliminary evaluation of transcription, translation and speech synthesis accuracy. *BMJ Innovations*. 2021;7(2). doi:10.1136/bmjinnov-2019-000347

31. Guidance - SAFE AI. April 24, 2024. Accessed July 1, 2024. https://safeaitf.org/guidance/

32. National Council on Interpreting in Health Care. Guidance For Healthcare Organizations Evaluating the Potential Use of AI-generated Interpreting. Published online July 2024. Accessed April 14, 2025. https://www.ncihc.org/assets/documents/publications/NCIHC%20guidance%20for%20contracting%20AI-generated%20interpreting%202024-07-15.pdf

33. Taira BR, Kreger V, Orue A, Diamond LC. A Pragmatic Assessment of Google Translate for Emergency Department Instructions. *J Gen Intern Med*. 2021;36(11):3361-3365. doi:10.1007/s11606-021-06666-z

34. Brewster RCL, Gonzalez P, Khazanchi R, et al. Performance of ChatGPT and Google Translate for pediatric discharge instruction translation. *Pediatrics*. 2024;154(1):e2023065573. doi:10.1542/peds.2023-065573

35. Lion KC, Brown JC, Ebel BE, et al. Effect of Telephone vs Video Interpretation on Parent Comprehension, Communication, and Utilization in the Pediatric Emergency Department. *JAMA Pediatrics*. 2015;169(12):1117. doi:10.1001/jamapediatrics.2015.2630

36. Flores G, Torres S, Holmes LJ, Salas-Lopez D, Youdelman MK, Tomany-Korman SC. Access to Hospital Interpreter Services for Limited English Proficient Patients in New Jersey: A Statewide Evaluation. *Journal of Health Care for the Poor and Underserved*. 2008;19(2):391-415.

37. Sleptsova M, Weber H, Schöpf AC, et al. Using interpreters in medical consultations: What is said and what is translated—A descriptive analysis using RIAS. *Patient Education and Counseling*. 2017;100(9):1667-1671. doi:10.1016/J.PEC.2017.03.023

38. Showstack RE, Guzman K, Chesser AK, Woods NK. Improving Latino Health Equity Through Spanish Language Interpreter Advocacy in Kansas. *Hispanic Health Care International*. 2019;17(1):18-22. doi:10.1177/1540415318818706

39. Chen AH, Youdelman MK, Brooks J. The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond. *J GEN INTERN MED*. 2007;22(2):362-367. doi:10.1007/s11606-007-0366-2

40. Youdelman MK. The medical tongue: U.S. laws and policies on language access. *Health Aff (Millwood)*. 2008;27(2):424-433. doi:10.1377/hlthaff.27.2.424