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Not-So-Equal Protection: Securing Individuals Of Limited English Proficiency With Meaningful Access To Medical Services

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COMMENT

NOT-SO-EQUAL PROTECTION: SECURING INDIVIDUALS OF LIMITED ENGLISH PROFICIENCY WITH MEANINGFUL ACCESS TO MEDICAL SERVICES

"Y entonces, coléricos, nos desposeyeron, nos arrebataron lo que habíamos atesorado: la palabra, que es el arca de la memoria."[1]

INTRODUCTION

Language discrimination takes many forms in the United States. It occurs directly when individuals are expressly forbidden to speak a language other than English, such as in employment situations where "English-only" policies are enforced.[2] It also takes place more indirectly, when persons are denied access to business or government services because they do not speak English.[3] This Comment explores language discrimination in health care settings.

Individuals are often unable to access medical services solely as a result of not speaking English. This is worsened by the fact that hospitals and other health care providers do little

[1] "Balún Canán," Rosario Castellanos. ["And then, madly, they dispossessed us, taking away from us what we had treasured: the word, which is the ark of memory"]

[2] *See, e.g.*, Equal Employment Opportunity Comm'n v. Premier Operator Services, Inc., 75 F. Supp. 2d 550 (N.D. Tex. 1999); Equal Employment Opportunity Comm'n v. Synchro-Start Products, Inc., 29 F.Supp. 2d 911 (N.D. Ill. 1999).

[3] *See, e.g.*, Kritz v. State of Alaska, Case No. 3DI-99-12CI (Super. Ct. of Alaska, Dist. III March 3, 1999); Alaskans for a Common Language, Inc. v. Kritz, 3 P. 3d 906 (Alaska 2000); Ruiz v. Hull, 191 Ariz. 441 (1998), *cert. denied*, 525 U.S. 1093 (1999).

to provide interpreters.[4] The failure to provider interpreters has serious consequences and can at times lead to death.

Take the case of Gricelda Zamora, a 13-year old Latina who died of a ruptured appendicitis.[5] At the time of her emergency room visit, she was unable to speak English and the hospital did not provide an interpreter. During her visit, the hospital gave her a pregnancy exam, but not a test to determine blood-clot levels that could have detected her burst appendix and thus saved her life. The attending physician assumed she was pregnant. As her family's lawyer points out, to immediately jump to the conclusion that a 13-year old Latina with abdominal pain is likely to be pregnant, rather than suffer from appendicitis, suggests stereotyping by the evaluating physician.[6] Had an interpreter been present, she would have been able to communicate with the physician and explain her symptoms.

As a result of this unavailability of interpreters in health care settings, individuals often have to rely on family and friends as interpreters.[7] But such informal interpretation is problematic. It not only results in semantic errors that distort care, but also breaches confidentiality and disturbs familial hierarchies and relationships.[8] Children, who are frequently asked to interpret for family members during doctor's visits, are particularly inadequate as interpreters because they are prone to omissions, additions and guessing.[9] The lack of linguistic competency in medical settings is not only dangerous

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[4] *See, e.g.*, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, BRIDGING LANGUAGE AND CULTURAL BARRIERS BETWEEN PHYSICIANS AND PATIENTS, 112 PUB. HEALTH REP., 410-417 (September/October 1997)[hereinafter BRIDGING LANGUAGE AND CULTURAL BARRIERS] (noting that according to a survey conducted in the Greater Bay Area of Northern California, physicians reported that 21% of their patients were non-English speaking, yet in 11 % of these encounters, no interpretation services were available or provided). *See also* Jane E. Allen, *World and Words Apart- Inadequate Interpreter Services for Non-English Speaking Patients Has Medical Experts and Civil Rights Advocates Concerned*, L.A. TIMES, November 6, 2000, at S1.

[5] Amanda Scioscia, *Language Isn't the Only Thing Getting Lost in Translation as Hispanic Patients Struggle to Communicate with English-speaking ER Doctors*, PHOENIX TIMES, June 29, 2000 (*at* http://www.lexis.com, News Group File).

[6] *Id.*

[7] JANE PERKINS, ET AL., NATIONAL HEALTH LAW PROJECT, ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES 11 (1998).

[8] *Id.*

[9] Lucy Tse, Letter from National Health Law Program to Tom Perez, *Language Brokering*, (1999), *at* http://www.healthlaw.org/pubs/19990720LEPGuidance.htm.

to a patient's health,[10] but also deprives individuals of an important right to adequate medical treatment.

As a number of studies demonstrate, the language barrier for patients of limited English proficiency was the most frequently cited obstacle to receiving care.[11] Language obstacles pose a serious impediment to the access to health care, prevention of illness, the success of health education efforts and compliance with physicians' orders.[12] These barriers impact a substantial number of individuals in this country. In California, for instance, nearly 11 million people are Latino and nearly 4.5 million are Asian or Pacific Islander.[13] At least 43% of Asians and 40% of Latinos speak a language other than English at home, and many are of limited English proficiency. For instance, in 1 out of 3 Asian households, everyone over the age of 14 has limited English proficiency.[14]

The detrimental effect of not providing adequate translation and interpreting services in the medical context is perhaps best illustrated in the area of worker's compensation law. In California, worker's compensation law underwent drastic reforms in 1993.[15] One of the centerpieces of the reform was the "doctor's presumption of correctness,"[16] which presumes that treating physicians are correct in their assessment of medical conditions and treatment.[17] Although

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[10] *See, e.g.* A.B. No. 2394 (Cal. 2000). This bill amends Cal. Business and Professions Code, Ch. 802, Sec. 852, at § 1(f) (2000), noting that "the lack of cultural and linguistic competency among medical providers may be dangerous to the health of certain patients" and at § 1(c), stating that, "without cultural competence, a physician may unintentionally incorporate racial biases into his or her interpretations of patients" symptoms, predications of patients' behaviors and medical decision making." *Id.* Additionally, § 852(a) establishes the Task Force on Culturally and Linguistically Competent Physicians and Dentists. *Id.*

[11] *See* Margaret M. Duffy & Amy Alexander, *Overcoming Language Barriers for Non-English speaking Patients*, 26(5) ANNA J., 507 (1999).

[12] *Id.*

[13] ASIAN & PAC. ISLANDER AM. HEALTH FORUM, CAL. PAN-ETHNIC HEALTH NETWORK, CTR. FOR HEALTH CARE RIGHTS, HEALTH ACCESS, LATINO ISSUES FORUM, NATIONAL HEALTH LAW PROGRAM & WESTERN CTR. ON LAW & POVERTY, CALIFORNIA HEALTH PLANS AND LANGUAGE ACCESS, 1 (2001).

[14] *Id.*

[15] *Treating Doctor's Presumption Axed in Senate Bill 320*, 9(13) CAL. WORKER'S COMP. ADVISOR (July 14, 1999).

[16] *Doctor's Presumption of Correctness Elimination Debated*, 10(9) CAL. WORKER'S COMP. ADVISOR (May 10, 2000).

[17] *Treating Doctor's Presumption Axed in Senate Bill 320, supra* note 15.

the presumption is rebuttable, it takes strong evidence to do so.[18]

Moreover, despite this strong presumption of correctness attributed to the treating physician, there is no requirement that an injured worker be provided with an interpreter. Because physicians who have access to trained interpreters report a significantly higher quality of patient-physician communication than physicians who use other methods, including bilingual staff,[19] the failure to provide an injured worker of limited English proficiency with an interpreter during an examination will prevent effective communication with the treating physician about relevant information, such as pain and symptoms. The importance of such communication seems to be frequently dismissed by physicians.

For instance, notwithstanding the frequency of language barriers reported in health care settings, only a small percentage of physicians consider obtaining a patient's informed consent problematic.[20] Courts, on the other hand, have recognized the importance of informed consent to medical procedures in negligence actions[21] and noted that existing language barriers obstruct a patient's ability to give fully informed consent.[22]

Cost is often claimed to be a reason for not providing interpreters in health care settings. In California, for instance, prior legislative efforts to have an interpreter provided during worker's compensation examinations were unsuccessful[23] and

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[18] *Doctor's Presumption of Correctness Elimination Debated*, *supra* note 16.

[19] *See* BRIDGING LANGUAGE AND CULTURAL BARRIERS, *supra* note 4, at 410-417.

[20] Duffy, *supra*, note 11, at 507.

[21] *See, e.g.*, Canterbury v. Spence, 150 U.S. App. D.C. Cir. 263 (1972); Logan v. Greenwich Hospital Ass'n, 191 Conn. 282 (1983).

[22] Powers v. United States, 589 F. Supp. 1084, 1098 (Conn. 1984). *See also*, Title VI of the Civil Rights Act: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52,762, 763 (August 30, 2000) [hereinafter HHS Policy Guidance](declaring that the accommodation of language differences through the provision of language assistance will not only promote compliance with Title VI, but provide better assurances of informed consent, which in turn will better protect providers against tort liability and malpractice lawsuits).

[23] *See* A.B. 201 Assembly Bill- History; *at* http://www.leginfo.ca.gov/pub/99-00/bil....0250/ab_201_bill_20000203_history.html (noting that A.B. 201, introduced by Sarah Reyes, D-Fresno, California, on January 21, 1999 so as to amend § 4600 of the Cal. Labor Code to require the provision of a qualified interpreter during examinations of the injured worker, died on February 3, 2000). *See also*, Laura Mahoney, *State Laws: Health Worker Protections, Bans on Fees to Job Applicants Among New*

strongly opposed by the Self-Insurers Association, which does not want to pay for interpreter services.[24] However, the absence of interpreters during these examinations has the effect of discriminating against individuals whose primary language is not English.[25] Contrary to the case of English-speakers, treating physicians are unable to fully communicate with individuals of limited English proficiency and can therefore not obtain an accurate assessment of the patient's condition.

Communication is a most fundamental element in the relationship between health care provider and patient, and health care suffers when accurate communication is not possible.[26] Absent accurate communication, several problems ensue: Physicians fill in the gaps and are likely to compile reports based on the physician's subjective beliefs, stereotypes surrounding manifest symptoms, and a diagnosis based on descriptions offered by the patient.[27] Furthermore, with an incomplete medical history, physicians remain unaware of the need for particular diagnostic investigations and have been found to therefore order fewer tests.[28]

In addition, bilingual staff members are not adequately available and often untrained.[29] For instance, providers even call on kitchen staff, housekeepers, maintenance workers or any other individual who may be available to meet an immediate need for communication without regard for their medical knowledge or their ability to interpret correctly.[30] Poor

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California Laws, 192 BNA Daily Lab. Rep., C-1 (October 5, 1998) (noting that in 1998, Governor Wilson vetoed A.B. 236 by Figueroa, which also would have allowed an employee who does not speak or understand English proficiently to have the services of a qualified interpreter during the course of medical treatment for worker's compensation purposes).

[24] *Wilson's Vetoed Bills Return, Get a Slow Reception*, 9(4) CAL. WORKER'S COMP. ADVISOR (Feb. 24, 1999).

[25] *See* HHS Policy Guidance, *supra* note 22, at 52, 763 (noting that in the absence of interpreters, or the reliance on untrained interpreters, the level and quality of health and social services available to persons of limited English proficiency stand in stark conflict to Title VI's promise of equal access to federally assisted programs and activities).

[26] Duffy, *supra* note 11, at 507.

[27] Sidney Watson, *Race, Ethnicity and Hospital Care: The Need for Racial and Ethnic Data*, 30 (2) AHA, J. Health L., 125 (June 1997)(*at* http://www.lexis.com, *Journal of Health Law).*

[28] Helen J. Binns et al., Language *Barriers and Resource Utilization in a Pediatric Emergency Department*, 103 AM. ACAD. OF PEDIATRICS, 1253, 1253-1256 (June 1999).

[29] JANE PERKINS, ET AL., *supra* note 7, at 13.

[30] *Id.* at 11.

communication also fuels problems created by treating physicians who are unaware of other cultures' deference to authority, descriptions of pain, and world-views about wellness and illness.[31] Without cultural competence, a physician may incorporate racial biases into his or her interpretations of patients' symptoms, predictions of patients' behaviors and medical decision-making.[32]

This Comment focuses on how language discrimination manifests itself in various health care settings and how it deprives individuals with limited or no English proficiency of access to a variety of essential medical services.[33] Part I of this article provides a brief overview of how courts and the legislature have dealt with language discrimination. Part II addresses the current conflict of the law regarding the difficulties in assessing and proscribing such discrimination in the medical context. Part III explores why the current case law and legislative efforts in this area are inadequate. Part IV proposes a solution as to how individuals with limited English proficiency may secure more meaningful access to medical services.

I. DEVELOPMENT OF LANGUAGE ACCESS RIGHTS

A. JUDICIAL TREATMENT

Several statutes, such as the Civil Rights Act of 1964,[34] the California Fair Employment and Housing Act[35] and the Civil Rights Act of 1866[36] protect an individual against language discrimination. Although these statutes do not contain a specific protection against discrimination on the basis of language, many courts and governmental agencies have

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[31] Watson, *supra* note 27, at 125.

[32] *Race, Gender and Partnership in the Patient-Physician Relationship*, 282(6) J. AM. MED. ASS'N. 583, 583-589 (1999).

[33] Such essential medical services include emergency room visits, diagnosis, operations, evaluations, prevention and treatment. Further obstacles arise regarding prescription information, informational leaflets, appointment letters and the signing of patient consent forms that are available only in the English language.

[34] 42 U.S.C. § 2000d (2001).

[35] CAL. Gov. Code § 12900 et seq.

[36] 42 U.S.C. § 1981 (2001).

construed language discrimination as a form of discrimination on the basis of race[37] or national origin.[38]

Title VI of the Civil Rights Act of 1964 has been an important tool in protecting and advancing language access rights in the context of governmental programs, or programs which are partially funded by the government. Like affirmative action and other policies designed to combat racial discrimination, the introduction of Title VI produced a ripple effect that went beyond race and national origin, benefiting women, the disabled, and other groups.[39] It became a blueprint for other anti-discrimination laws, such as Title XI of the Education Amendments of 1972,[40] the Rehabilitation Act of 1974[41] and Title II of the Americans with Disabilities Act.[42]

Specifically, Section 601 of Title VI provides that "no person in the United States shall, on the ground of race, color 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."[43] Shortly after passage of Title VI, there was little dispute that Section 601 was aimed to prohibit not only intentional discrimination (as clearly forbidden by a textual reading of Section 601), but also the more subtle form of discrimination termed "disparate impact."[44] Therefore, the implementing

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[37] Hernandez v. New York, 500 U.S. 352, 371 (1991) ("It may well be, for certain groups and in some communities, that proficiency in a particular language, like skin color, should be treated as a surrogate for race under an equal protection analysis.").

[38] Olagues v. Russoniello, 797 F. 2d 1511, 1520 (9th Cir. 1986) (noting that "an individual's primary language flows from his or her national origin"), *cert. granted*, 481 U.S. 1012 (1987), *vacated, remanded en banc*, 832 F. 2d 131 (9th Cir. 1987). *See also* Asian Am. Bus. Group v. City of Pomona, 716 F. Supp. 1328, 1332 (C.D. Cal. 1989)(holding that the use of foreign languages is clearly an expression of national origin, which is a suspect classification requiring the application of strict scrutiny).

[39] MEXICAN AMERICAN LEGAL DEFENSE AND EDUCATION FUND & APPLIED RESEARCH CENTER, SUPREME COURT BLUNTS CIVIL RIGHTS SWORD WITH SANDOVAL DECISION, SPECIAL TO COLORLINES MAGAZINE, *at* www.colorlines.com (August 6, 2001)[hereinafter SUPREME COURT BLUNTS CIVIL RIGHTS].

[40] *See* 7 U.S.C. § 301 (2001)

[41] *See* 29 U.S.C. § 701 (2001).

[42] SUPREME COURT BLUNTS CIVIL RIGHTS, *supra* note 39.

[43] 42 U.S.C. § 2000d (2001).

[44] *See* Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination - It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939, 948 (1990) (noting that a disproportionate adverse impact theory reflects an equal opportunity conception of reality which imposes an affirmative duty on defendants to heed the disproportionate consequences of their policies because structural, historical or societal barriers have impeded equal achievement).

regulations promulgated under Section 602 (which asks various federal agencies to put into practice the anti-discrimination mandate of Section 601)[45] also incorporate a prohibition against discrimination through disparate impact. They do so by prohibiting administration methods that have the *effect* of discriminating against minorities.[46] Since today almost all hospitals accept federal funds, they come within the reach of Title VI.[47] Furthermore, their administration and policies are subject to the regulations promulgated by the Department of Health and Human Services (hereinafter "HHS") pursuant to Section 602.[48]

The Title VI implementing regulations also provide for an administrative enforcement mechanism through the Office of Civil Rights (hereinafter "OCR").[49] They permit the OCR to attempt to obtain compliance among fund recipients through voluntary or informal means.[50] In cases of ongoing failure to comply, the governing agency may terminate funding.[51] This administrative complaint mechanism has been criticized for being inefficient, as well as deficient in its enforcement and monitoring responsibilities.[52]

In addition to the administrative complaint procedures, Title VI regulations have been interpreted and enforced through the courts.[53] The ability of Title VI plaintiffs to

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[45] 42 U.S.C. § 2000d-1(2001) (authorizing federal agencies "to effectuate the provisions of § 601's anti-discrimination mandate by issuing rules, regulations, or orders of general applicability").

[46] Watson, *Reinvigorating Title VI, supra* note 44 at 948 (explaining that the theory of disproportionate adverse impact outlaws practices that are facially neutral but fall more harshly on minorities and that cannot be justified). *See, e.g.*, 49 C.F.R. § 21.5 (b)(2) (2001) (noting that with regard to nondiscrimination in federally-assisted programs of the Department of Transportation, "a recipient... may not... utilize criteria of methods of administration which have the *effect* of subjecting persons to discrimination because of their race, color or national origin, or have the *effect* of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular race, color or national origin") (emphasis added). *See also* 28 C.F.R. 42.104(3) (2001), (proscribing disparate impact discrimination by the Department of Justice); 45 C.F.R. § 80 et seq. (2001) (proscribing policies with discriminatory impact by the Department of Health and Human Services).

[47] Watson, Reinvigorating Title VI, *supra* note 44 at 944.

[48] 45 C.F.R. § 80 et seq. (2001).

[49] 45 C.F.R. § 80.8 (2001).

[50] 45 C.F.R. § 80.8(a) (2001).

[51] 45 C.F.R. § 80.8(a), (b), (c) (2001).

[52] Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1669 (1993).

[53] *See, e.g.*, Guardians Ass'n v. Civil Serv. Comm'n, 463 U.S. 582 (1983); University

challenge facially neutral policies with a disparate impact has been considered the main strength of a Title VI action.[54] For instance, in the landmark case of *Lau v. Nichols*, a unanimous Supreme Court in 1974 interpreted Section 601 as prohibiting disparate-impact discrimination.[55] Students of Chinese ancestry had brought a class action suit against the San Francisco Unified School District for failure to provide equal educational opportunities to non-English speaking students.[56]

Specifically, plaintiffs alleged that San Francisco's school system's facially neutral policy of not providing supplemental English language instruction violated Title VI because it had the effect of excluding non-English speaking students from the school's educational programs. In interpreting Section 601, the court relied on regulations promulgated by the Department of Health, Education and Welfare. These regulations require federally funded school districts to *rectify* existing language deficiencies.[57]

The Supreme Court held that the school district's failure to provide the students with supplemental English language instruction violated Title VI of the Civil Rights Act of 1964 *because it deprived them of a meaningful opportunity to participate in the public school system.*[58] The Court reasoned that even though standards such as those set forth in California's Education Code[59] did not explicitly discriminate against any particular class, they also did little to ensure equal treatment of students. As the court noted, merely providing students with the same facilities, textbooks, teachers and

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of Cal. Regents v. Bakke, 438 U.S. 265 (1978); Lau v. Nichols, 414 U.S. 563 (1974).

[54] Daniel K. Hampton, Note, *Title VI Challenges by Private Parties to the Location of Health Care Facilities: Toward a Just and Effective Action*, B.C. L. REV. 517, 554 (1996).

[55] 414 U.S. at 566-567 (explaining that the court relied solely on § 601 of the Civil Rights Act of 1964 (42 USC § 2000d) to reverse the Court of Appeals and that the purpose of the disparate-impact regulations was merely to ensure that recipients of federal aid conduct their federally financed projects consistently with § 601).

[56] *Lau*, 414 U.S. at 563 (1974).

[57] 35 Fed. Reg. 11,595 (1970) ("Where inability to speak and understand the English language excludes national origin-minority group children from effective participation in the educational program offered by a school district, the district must take affirmative steps to rectify the language deficiency in order to open its instructional program to these students.") (cited in *Lau*, 414 U.S. at 568).

[58] *Lau*, 414 U.S. at 568.

[59] *See generally* CAL. EDUC. CODE §§ 71, 8573, and 12101 (West 1974) (cited in *Lau*, 414 U.S. at 565-567).

curriculum does not translate into equal treatment, since students who do not understand English will be unable to benefit from the class room experiences that lie at the heart of public education.[60] This interpretation was consistent with the regulations promulgated pursuant to Section 602 by the Department of Health, Education and Welfare, which proscribe a policy that is discriminatory in *effect* as to the availability or use of academic facilities, because such a policy substantially impairs accomplishment of the program's objectives, even if a purposeful design to discriminate is absent.[61]

By analogy, the failure to provide language assistance in health care settings has a similar effect of excluding non-English speakers from essential medical services. Furthermore, it has the effect of discriminating on the basis of national origin, which is prohibited by Title VI. As early as 1980, the Department of Health and Human Services (hereinafter "HHS") recognized that "because persons of limited English are disproportionately represented in certain national origin groups, the inability to communicate with persons of limited English proficiency has the effect of discriminating on the basis of national origin" and further noted that "no person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English."[62]

More recently, the Department of Justice (DOJ) and the Department of Health and Human Services promulgated policy guidelines on how to improve access to services for persons with limited English proficiency as a way to prevent and diminish national origin discrimination.[63] These guidelines reiterate that Title VI regulations prohibit both discriminatory policies that are intentional and those that have a discriminatory effect. For instance, the HHS Guidance notes that the failure to provide language assistance for non-English

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[60] *Lau*, 414 U.S. at 566.

[61] 45 C.F.R. § 80.3 (b)(1) (1974).

[62] Nondiscrimination on the Basis of Race, Color or National Origin Under Programs Receiving Federal Financial Assistance Through the Department of Health and Human Services, 45 Fed. Reg. 82, 972 (Dec. 17, 1980) (Notice).

[63] *See* Enforcement of Title VI of the Civil Rights Act of 1964: National Origin Discrimination Against Persons with Limited English Proficiency, Policy Guidance, 65 Fed. Reg. 50,123 (August 16, 2000) [hereinafter "DOJ Policy Guidance"]; HHS Policy Guidance, *supra* note 25, at 52,762.

speakers in the health and social service sector has the effect of denying and delaying essential services.[64] It further recognizes that the consequences of denying access to such services are serious, at times life-threatening and generally constitute discrimination on the basis of national origin.[65]

Thus, entities charged with the implementation of the Civil Rights Act have considered *Lau's* ruling as one applicable to medical settings and attributed to health care providers an affirmative duty to rectify existing language barriers.[66] Consequently, OCR guidelines mandate that physicians and other health care providers supply interpretation services if they accept reimbursement under Medicaid, the State Children's Health Insurance Program, or the Temporary Assistance to Needy Families Program.[67]

In accordance with this interpretation of *Lau*, attorneys have been filing administrative complaints against hospitals that breach their duty to provide translation and interpreting services. For instance, in Ohio, Advocates for Basic Legal Equality (ABLE) represented non-English speaking patients in a lawsuit against Ohio for failure to provide services in Spanish at its public health centers.[68] The complaint, which was filed with the Department of Health and Human Services, alleged that two federally funded health centers failed to provide services in Spanish and thus denied patients access to adequate health care.[69] The parties reached a settlement, wherein the health care center agreed to provide language assistance.[70]

In harmony with the Office of Civil Rights' review of administrative complaints, the Supreme Court also continued to rely on disparate impact theories in deciding Title VI cases.

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[64] HHS Policy Guidance, *supra* note 22, at 52,763.

[65] *Id.*

[66] Susan J. Landers, Doctors *Resent Being Forced to Find, Pay for Interpreters,* AM. MED. NEWS, Nov. 20, 2000.

[67] *Id.* The American Medical Association and other state medical specialty groups have disputed this interpretation of *Lau. Id.*

[68] Plaintiff's Complaint at 1-2, Advocates for Basic Legal Equal., Inc. v. Cordelia Martin Health Ctr., HHS Admin. Complaint (Feb. 7, 2001).

[69] *Id.*

[70] Settlement between HHS Investigator and Cordelia Martin Health Care Ctr., Advocates for Basic Legal Equal., Inc. v. Cordelia Martin Health Ctr. (November 8, 2001).

In the case of *Alexander v. Choate*, for instance, the court unanimously stated:

> In essence, then, we have held that Title VI had delegated to the agencies in the first instance the complex determination of what sorts of disparate impacts upon minorities constituted sufficiently significant social problems and were readily enough remediable, to warrant altering the practices of the federal grantees that have produced those impacts.[71]

Similarly, in *Guardians Assoc. v. Civil Serv. Comm'n of New York*, the Supreme Court also recognized that the Court of Appeals erred in requiring proof of discriminatory intent to establish a violation of Title VI.[72] This is also consistent with *NAACP v. Brennan*, where the court read Title VI as imposing upon federal officials not only a duty to refrain from participating in discriminatory practices, but also an affirmative duty to police operations and prevent such discrimination by state and local agencies funded by them.[73]

Thus, in examining the provision of interpreters and other forms of language assistance in the medical context and possible civil rights violations, the regulations by the Department of Health and Human Services apply. Consistent with the Supreme Court's interpretation in *Lau* and other federal regulations implementing Section 601,[74] these regulations have long proscribed a policy that is discriminatory in *effect* even if no intentional discrimination is present.[75] This has further been affirmed in HHS's recent policy guidance, which specifically addresses adverse impact discrimination against non-English speakers.[76]

B. LEGISLATIVE EFFORTS

States and local agencies have also enacted legislation mirroring the Title VI mandate to remedy the fact that non-English speakers are being denied the opportunity to

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[71] 469 U.S. 287, 293 (1985).

[72] 463 U.S.582, 584 (1983).

[73] 360 F. Supp 1006 (D.C. 1973). *See also Lau*, 414 U.S. 563.

[74] *See, e.g.*, 49 C.F.R. § 21.5 (b)(2); 28 C.F.R. § 42.104(3); 45 C.F.R. § 80 et seq. (2001).

[75] 45 C.F.R. § 80.3 (b)(1) (2001).

[76] HHS Policy Guidance, *supra* note 22 at 52, 762.

"meaningfully participate" in government services and programs in the same manner as English-speakers.[77] For instance, the California Dymally-Alatorre Bilingual Services Act of 1973 (hereinafter "Bilingual Services Act") attempts to equalize such disparate treatment.[78] The Bilingual Services Act declares that "the effective maintenance and development of a free and democratic society depends on the right and ability of its residents to communicate with their government."[79] Thus, it requires bilingual staffing and services at each state agency when 5% or more of its consumers speak a language other than English, to be determined by regularly conducted language surveys.[80] The Bilingual Services Act also requires bilingual staffing and translation of materials of local agencies if a substantial number of its consumers are non-English speaking.[81]

Similarly, San Francisco passed a local ordinance in June of 2001 to ensure "Equal Access to City Services for Limited English Speakers."[82] This ordinance implements and supplements the Bilingual Services Act,[83] by requiring state and local public agencies serving a substantial number of limited English-speaking people to provide services and materials in the language(s) spoken by those persons.[84]

Such state and local legislation has been an important tool in advancing language access rights by way of litigation. For instance, in the case of *Martinez v. Millan,*[85] a class of non-English speakers brought suit against the California Labor Commission, claiming that a lack of translation services violated the Labor Code[86] and the Bilingual Services Act.[87] As

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[77] *See, e.g.,* CAL. GOV.'T CODE § 7292 (West 2001); SAN FRANCISCO, CAL., ADMIN. CODE Ch. 89, §§ 89.1, 82.2 and 89.4-14 (2001).

[78] CAL. GOV.'T CODE § 7292 (West 2001).

[79] CAL. GOV.'T CODE § 7292 (West 2001).

[80] BUREAU OF STATE AUDITS, CALIFORNIA STATE AUDITOR, DYMALLY-ALATORRE BILINGUAL SERVICES ACT: STATE AND LOCAL GOVERNMENTS COULD DO MORE TO ADDRESS THEIR CLIENTS' NEEDS FOR BILINGUAL SERVICES 6 (1999).

[81] *Id.* at 7. The determination of what constitutes a substantial number of persons, however, is not defined for local agencies and left to their discretion. *Id.*

[82] SAN FRANCISCO, CAL., ADMIN. CODE ch. 89, §§ 89.1, 82.2 and 89.4-14 (2001).

[83] Cal. Gov. Code § 7290 (West 2001).

[84] SAN FRANCISCO, CAL., ADMIN. CODE ch. 89, §§ 89.1, 82.2 and 89.4-14 (2001).

[85] *See* Petition for Writ of Mandate and Declaratory Relief, No. 204273, Cal. Super. Court, Sonoma County (February 19, 1993).

[86] CAL. LAB. CODE § 105(a) (West 2001).

[87] CAL. GOV. CODE § 7290 (West 2001).

a result of the lawsuit, the Labor Commissioner approved a settlement agreeing to provide foreign-language interpreters, as needed in the course of spoken communications between its employees and non-English-speaking members of the general public.[88] It also agreed to translate all appropriate forms and written materials for a "substantial number of non-English-speaking people" within the meaning of the Bilingual Services Act.[89]

Thus, efforts to enforce legislation aimed at advancing rights of non-English speaking individuals in addition to Title VI, especially at the state level, are also relevant to the provision of health care services. Individuals who are being denied access to governmentally provided medical care could therefore challenge the monolingual provision of health care services also through existing legislation.

II. THE CURRENT STATE OF THE LAW

Due to the recent United States Supreme Court decision in *Alexander v. Sandoval*,[90] Section 601 of the Civil Rights Act has now been interpreted narrowly to prohibit only *intentional* discrimination, even though the implementing regulations made pursuant to Section 602 more broadly prohibit programs with *discriminatory effect*, i.e. programs that are facially neutral but discriminatory because of their disparate impact on a particular group. In *Sandoval*, plaintiffs sued the Director of State Public Safety in Alabama under Title VI for administering driver's license examinations in English only. Plaintiffs argued that such policy violated federal regulations which prohibit recipients of federal funds to engage in conduct that has the effect of subjecting individuals to national origin discrimination.[91] Both the District Court and the Court of Appeals for the Eleventh Circuit found that the policy had the effect of subjecting non-English speakers to national origin discrimination.[92]

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[88] Petition for Writ of Mandate and Declaratory Relief, Martinez v. Millan, No. 204273, Cal. Super. Court, Sonoma County (February 19, 1993).

[89] Order Approving Settlement Agreement and General Release, Martinez v. Millan, No. 204273, Cal. Super. Court, Sonoma County (January 6, 1999).

[90] 532 U.S. 275 (2001).

[91] *Id.*

[92] *Id.* at 279.

The Supreme Court, however, held that even though regulations promulgated under Section 602 may validly proscribe activities that have a disparate impact on particular groups, such disparate-impact regulations may not be enforced through a private right of action.[93] This has been viewed as eliminating 25 years of legal precedent to the contrary, and civil rights activists are concerned.[94] A spokesperson for the ACLU's Racial Justice Project, for instance, voices concern because virtually all of their major cases are predicated, at least in part, on a disparate impact theory.[95]

Sandoval also casts doubt on the continued validity of the disparate impact implementing regulations, and how their mandate will now apply to the provision of interpreter services in the medical context.[96] For instance, *Sandoval* may have invalidated the above-mentioned recent Title VI HHS and DOJ policies against disparate impact discrimination affecting people with limited English skills.[97] The current position of the DOJ is that *Sandoval* has not invalidated the Title VI disparate impact regulations.[98]

In any event, the regulations, which are currently in place, rely as legal authority on the Eleventh Circuit's decision in *Sandoval,* which has now been overturned. For instance, the HHS policy elaborates that, in *Sandoval*, the vast majority of individuals who were adversely affected by Alabama's English-only driver's license examination policy were national origin minorities and that the policy violated Title VI on a disparate impact theory.[99] A similar policy guidance by the Department of Labor on Title VI enforcement contains an identical

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[93] *Id.* at 289.

[94] SUPREME COURT BLUNTS CIVIL RIGHTS, *supra* note 39.

[95] SUPREME COURT BLUNTS CIVIL RIGHTS, *supra* note 39.

[96] Memorandum for Heads of Departments and Agencies, General Counsels and Civil Rights Directors, DOJ, (October 26, 2001), *at* http://www.usdoj.gov/crt/cor/lep/Oct26Memorandum.htm [hereinafter "DOJ Memorandum"] (noting that some have interpreted *Sandoval* as impliedly striking down Title VI's disparate impact regulations and thus that part of Executive Order 13166 as it applies to federally assisted programs and activities).

[97] *See* DOJ Policy Guidance, *supra* note 63, at 50,123; HHS Policy Guidance, *supra* note 22, at 52, 763.

[98] DOJ Memorandum, *supra* note 96.

[99] HHS Policy Guidance, *supra* note 22, at 52,765.

statement regarding the Court of Appeals' decision in *Sandoval*.[100]

Furthermore, the Supreme Court's decision in *Sandoval* establishes that plaintiffs can only sue if they can show *deliberate* discrimination.[101] This poses a serious threat to language-based discrimination claims. Today most government agencies are sophisticated enough not to make incriminating statements or leave a paper trail of evidence showing discriminatory intent, thus making it difficult to bring a claim.[102]

In the medical context, this may now mean that federally funded hospitals or agencies which do not supply interpreters or other forms of language assistance that would ensure non-English speakers equal access to their services are complying with Title VI mandates unless they *specifically intend* to discriminate. Commentators note that proof of intentional discrimination in the health care context is difficult.[103] Thus, it will become increasingly more burdensome to change health care policies and programs that adversely impact non-English speakers through the court system. Because such issues of proof may be difficult to overcome, litigation as a tool for challenging programs that nevertheless have a disparate impact has now been weakened or totally eliminated.[104]

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[100] *See* Enforcement of Title VI of the Civil Rights Act of 1964, Policy Guidance on the Prohibition Against National Origin Discrimination As it Affects Persons with Limited English Proficiency, 66 Fed. Reg. 4596, 4598 (January 17, 2001).

[101] *Sandoval*, 532 U.S. at 285-286 (declaring "We have since rejected *Lau's* interpretation of § 601 as reaching beyond intentional discrimination.... It is clear now that the disparate-impact regulations do not simply apply 601B since they indeed forbid conduct that § 601 permits and therefore clear that the private right of action to enforce § 601 does not include a private right to enforce these regulations.").

[102] *See* SUPREME COURT BLUNTS CIVIL RIGHTS, *supra* note 39. *See also* Lora v. Bd. of Educ., 623 F. 2d 248, 251 (2d Cir. 1980) (holding that inferences from evidence of discriminatory impact were not sufficient to show a violation of 42 U.S.C. § 2000d, absent actual motivation and that discriminatory purpose as a motivating factor must be found to conclude the existence of a constitutional violation).

[103] Hampton, *supra* note 54, at 531.

[104] *See, e.g.*, Steptoe v. Sav. of Am., 800 F Supp. 1542, 1548 (N.D. Ohio 1992) (dismissing homeowners' Title VI claim under U.S.C. § 2000d because there was *no proof* (emphasis added) that the mortgage lender, who allegedly sabotaged black buyers' chance to buy a home in a predominantly white neighborhood, used federal funds to do so). The court granted summary judgment on the Title VI claim even though it acknowledged that a racially discriminatory effect could be inferred. *Id.* at 1546.

III. CRITICISM OF THE PRESENT STATE OF THE LAW

The ability to provide non-English speakers with effective translation services in the medical context remains an ongoing challenge. I will discuss problems that arise in the judicial and legislative arena separately.

A. JUDICIAL EFFORTS AND THE IMPORTANCE OF LANGUAGE ASSISTANCE IN HEALTH CARE SETTINGS

Sandoval stands in stark contrast to the Supreme Court's initial interpretation of Section 601 in the 1974 *Lau* decision.[105] At the same time, a theory of disparate impact remains crucial in advancing language access rights. Although federally funded health care entities are careful not to formulate any policies that encourage exclusion of non-English speakers from its services, it would be near-sighted to ignore the reality that language barriers represent one of the major obstacles to receiving quality health care in the United States. If medical services are made available only in English, and a substantial number of potential recipients are of limited English proficiency, they are being denied meaningful access to vital services.[106]

Even though the failure to rectify such language barriers may not meet the current definition of intentional discrimination, it nevertheless has the adverse effect of denying national origin minorities meaningful access to governmental programs and services. Thus, similar to the court-imposed mandate to provide supplementary English instruction to Chinese students in *Lau*, health care providers should be under a duty to provide interpreters and other forms of language assistance.

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105 414 U.S. at 568.

106 HHS Policy Guidance, *supra* note 22, at 52,762.

B. SHORTCOMINGS OF CURRENT LEGISLATION AIMED AT IMPROVING LANGUAGE ACCESS RIGHTS

Legislative efforts to remedy the exclusion of language minorities from access to health care are insufficient. This is well illustrated by California's Bilingual Services Act. It suffers from several shortcomings that significantly limit the primary purpose of providing equal access to services. Firstly, it contains no monitoring provisions for compliance and no enforcement mechanisms.[107] This makes it difficult to determine whether agencies are implementing sufficient steps to ensure equal access to services. Furthermore, existing law under the Bilingual Services Act does not offer aggrieved parties an opportunity to seek administrative or judicial review when alleging a violation of the Act's provision.[108] This, of course, creates little incentive for agencies to comply with the law.

A recent report by the California State Auditor demonstrates that existing law fails to ensure equality in access to medical services.[109] During a two-year period, nearly 45,000 people potentially received inadequate medical services because state agencies did not have bilingual staff members to assist in interpretation.[110] The Yolo County Health Department, for instance, identified six languages for which it provides no bilingual services at all.[111] Thus, individuals seeking medical treatment who only speak one of those languages may not receive the medical care they need because of the language barriers.[112] Furthermore, although the Bilingual Services Act requires state agencies to conduct language surveys to determine bilingual needs, state agencies rely on outdated language surveys or have not established any

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107 CAL. COMMITTEE ANALYSIS STATEMENT, S.B. 987, BILL ANALYSIS (May 31, 2001) (*at* http://www.lexis.com, CA Legislative Committee Analysis of Pending Bills).

108 CAL. COMMITTEE ANALYSIS STATEMENT, S.B. 987, BILL ANALYSIS (April 24, 2001) (*at* http://www.lexis.com, CA Legislative Committee Analysis of Pending Bills).

109 BUREAU OF STATE AUDITS, CALIFORNIA STATE AUDITOR, *supra* note 80, at 1.

110 *Id.* at 16.

111 *Id.* at 27.

112 *Id.*

procedures to assess their ability to provide bilingual services to clients.[113]

In addition, the Bilingual Services Act does not define what constitutes "a substantial number of non-English speaking persons" to guide local agencies, thus leaving room for discretion in determining in which languages, if any, they should provide services.[114] This, in turn, allows local agencies to circumvent the law and maintain the existing, unequal level of services to its constituents that the Bilingual Services Act was meant to remedy.

In sum, claims against discrimination on the basis of language in health care settings continue to be difficult to advance for several reasons. Because language-based discrimination cases are frequently claims of disparate impact, and the Supreme Court recently eliminated the right to bring a private action based on such disparate impact claims, claimants are left with little recourse. They may still file a complaint with the administrative agency (OCR), but in reality, the ability to sue in court is crucial for the advancement of Title VI discrimination claims.[115] Furthermore, legislation that has been enacted to remedy translation and interpretation needs does not contain provisions to enforce compliance with its mission to provide bilingual services and, in addition, offers no or limited judicial review.[116] Worker's compensation laws and procedures that fail to recognize the importance of translation and interpreting services compound this.

IV. PROPOSED SOLUTION: ADVANCING THE OPPORTUNITY FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY TO MEANINGFULLY ACCESS MEDICAL SERVICES

The ability of plaintiffs to bring a private right of action to challenge policies with a disparate impact in health care

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[113] *Id.* at 12.

[114] *Id.* at 6.

[115] SUPREME COURT BLUNTS CIVIL RIGHTS, *supra* note 39.

[116] *See, e.g.*, Expert Ignatius Bau's Written Testimony, as Deputy Director, Asian Pacific Islander American Health Forum, at Public Hearing before the Task Force on Culturally and Linguistically Competent Physicians and Dentists, at 6 (San Francisco, CA, November 9, 2001) (noting that California should be more proactive in monitoring state language access laws such as the Dymally-Alatorre Bilingual Services Act).

settings is crucial and needs to be preserved. This is particularly so because statutes, programs and policies in the health care context can rarely be challenged under current definitions of intentional discrimination. Furthermore, because the Title VI statute itself lacks specificity, the Supreme Court has considered the agency's more detailed anti-discrimination regulations as crucial in determining private rights of action. Federal agencies have expressly recognized the detrimental discriminatory effect of excluding language minorities from access to health care services and attempted to remedy such disparate impact.[117]

At the same time, the administrative enforcement procedure of Title VI through the OCR, which remains unaffected by *Sandoval*, is insufficient to remedy the denial of meaningful access of non-English speakers to health care services. The OCR suffers from several shortcomings, such as inefficiency and a decreasing interest in ensuring compliance with and enforcement of the disparate impact regulations.[118] Notwithstanding recognizable efforts by the OCR, those who suffer discrimination in the health care context should have legal recourse in addition to its administrative complaint procedure. Limiting enforcement of Title VI's anti-discrimination mandate to agencies charged with overseeing implementation of their own regulations carries an inherent bias and is simply insufficient to advance the rights of non-English speaking persons who are being deprived of access to health care services.

For instance, in 1994, plaintiffs brought a Title VI claim in the United States District Court of California requesting a preliminary injunction blocking the construction of a new hospital, which would have had a disparate impact on minority members of Contra Costa County.[119] They had previously filed an administrative complaint with the OCR, which issued an opinion concluding that the County had complied with Title VI.[120] The District Court reached the opposite conclusion. It recognized the disparate impact and granted plaintiffs the

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[117] HHS Policy Guidance, *supra* note 22, at 52,763.

[118] Hampton, *supra* note 54, at 524-525.

[119] Latimore v. County of Contra Costa, No. C 94-1257, slip op. (N.D. Cal. Aug. 1, 1994).

[120] *Id.* at 4.

preliminary injunction until equal access to county hospital services was made available.[121] Had it not been for the private right of action to further challenge the OCR's determination, the violation of Title VI would have continued. After *Sandoval*, this avenue has now been eliminated.

As it may be difficult to overturn the *Sandoval* decision due to the increasingly conservative trend in the composition of the Supreme Court, as well as a general reluctance of the Supreme Court to overturn its own decisions absent extraordinary societal changes,[122] other approaches and legal arguments to Title VI violations should be explored.

A. THE CASE FOR AN EQUAL PROTECTION ARGUMENT

Policies and programs that have the effect of excluding non-English speakers from meaningful access to health care should also be challenged on equal protection grounds. Most disparate impact cases that alleged Title IV violations and challenged its implementing regulations did not raise an equal protection claim. This is because the Equal Protection Clause has been considered to prohibit only intentional discrimination.[123]

A close reading of the case law, however, demonstrates that the type of "intentional discrimination" required to establish an equal protection violation might be less stringent than it appears. For instance, the very case that restricted the reach of the Equal Protection Clause to instances of purposeful discrimination also reaffirmed that such discrimination could be inferred from effects and contextual data, such as a law's disparate impact on minorities.[124] As Justice Stevens has noted, "the line between discriminatory purpose and

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[121] *Id.* at 32-33.

[122] Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 861 (1992).

[123] Washington v. Davis, 426 U.S. 229, 238-248 (1976).

[124] *Id.* at 242. ("Necessarily, an invidious discriminatory purpose may often be inferred from the totality of the relevant facts, including the fact that the law bears more heavily on one race than another. It is also not untrue that the discriminatory impact may, for all practical purposes, demonstrate unconstitutionality because in various circumstances the discrimination is very difficult to explain on non-racial grounds."). *See also* Arlington Heights v. Metro. Hous. Dev. Corp., 429 U.S. 252, 265-266 (1977).

discriminatory impact is neither as bright nor as critical as the Court believes it to be."[125]

There are several ways in which evidence of purposeful discrimination in the provision of health care services to non-English speakers can be presented under an equal protection claim. First, the collection of data regarding individuals' primary language needs to improve. Although collection of such data has been deemed an important goal in the national health care debate,[126] a recent study by the National Health Law Program shows that such data collection suffers from several shortcomings.[127]

Despite regulations of the Department of Health and Human Services, for instance, which call for the collection of racial, ethnic and primary language data,[128] these provisions are not systematically enforced.[129] In addition, it was found that there is insufficient knowledge of policies regarding implementation of data collection.[130] This is coupled with the fact that data collection on the basis of primary language within health care settings is a relatively recent phenomenon,[131] thus requiring the alteration of current data gathering methods so as to include statistics on that basis.

These shortcomings have been deplored by other entities as well. For instance, at a public hearing before the Task Force on Culturally and Linguistically Competent Physicians and Dentists in California, an expert testified in his capacity as Deputy Director of the Asian and Pacific Islander American Health Forum that there are significant gaps and lapses in the

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[125] Hernandez v. New York, 500 U.S. 352, 377-378 (1991) (citing *Davis*, 426 U.S. at 254).

[126] RUTH PEROT & MARA YOUDELMAN, THE COMMONWEALTH FUND, RACIAL, ETHNIC AND PRIMARY LANGUAGE DATA COLLECTION IN THE HEALTH CARE SYSTEM: AN ASSESSMENT OF FEDERAL POLICIES AND PRACTICES v-vi (2001) ("Persistent evidence of differences in medical treatment and health outcomes has focused attention on how race, ethnicity and English proficiency can affect access to quality health care. Indeed, the issue of racial and ethnic disparities has taken center stage in the national health care debate. This in turn has led to the importance of collecting date regarding ethnicity, primary language and race. Finding #3: General agreement prevails that racial, ethnic and primary language data are critical to promote health and quality health care for all Americans.").

[127] *Id.* at 3.

[128] 42 C.F.R. § 80.4 (a) (2001).

[129] PEROT &YOUDELMAN, *supra* note 126, at 21.

[130] *Id.*

[131] *Id.* at 8.

collection, analysis and dissemination of data regarding primary language of health consumers.[132] He also called for the collection, analysis and availability of disaggregated data.[133] And the California State Auditor notes that even though the Bilingual Services Act requires state agencies to conduct language surveys to determine bilingual needs, state agencies have relied on outdated language services or failed to establish any procedures to assess their ability to provide bilingual services.[134]

Therefore, state and federal agencies should be pressured to comply with their obligation to collect data. Such data should be analyzed in conjunction with data gathered from non-governmental sources. These data will assist in proving how non-English speakers are disproportionately excluded from access to health care services. Because evidence that a group has been disparately impacted by a policy or procedure has been considered an element in proving purposeful discrimination in equal protection claims, an extensive and diverse collection of primary language data can prove purposeful discrimination of non-English speakers in the health care context. Such statistics will also serve to demonstrate the strong correlation between national origin and primary language.[135]

The argument that non-English speakers are purposefully discriminated against in health care settings can be strengthened in other ways. As Justice Marshall noted in his dissent in *Feeney,* in order to determine purposeful discrimination, the court has considered the degree, inevitability and foreseeability of any disparate impact.[136] The foreseeable impact of excluding non-English speakers from access to health care services is expressed clearly in HHS' longstanding position that, in order to avoid discrimination

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[132] *See, e.g.,* Expert Ignatius Bau's Written Testimony, *supra* note 116, at 5-6.

[133] *Id.*

[134] BUREAU OF STATE AUDITS, CALIFORNIA STATE AUDITOR, *supra* note 80, at 12.

[135] Lori A. McMullen & Charlene R. Lynde, Comment, *The "Official English" Movement and the Demise of Diversity: The Elimination of Federal Judicial and Statutory Minority Language Rights,* 32 LAND AND WATER L. REV. 789, 813 (1997) (citing Leonardo Estrado, *The Extent of Spanish/English Bilingualism in the United States,* 15 AZTLAN INT'L J. CHICANO STUD. RES. 379. 381 (1984) (noting that roughly 97% of individuals who speak Spanish are Latino). *Id.*

[136] Personal Adm'r of Mass. v. Feeney, 442 U.S. 256, 283 (1979) (Marshall, J., dissenting).

against persons with limited English proficiency, health and social service providers must take adequate steps to ensure that such individuals receive language assistance free of charge to afford them meaningful access to their services.[137] This position, which has recently been reiterated in the afore-mentioned policy guidance, is, at a minimum, indicative of HHS' awareness that such discrimination exists and warrants a remedy.

Thus, even in light of *Sandoval*, the failure to rectify such situations through language assistance would be tantamount to purposeful discrimination under an equal protection analysis, as it is foreseeable that the failure to provide such assistance will foster discrimination. Improved data collection will also serve to substantiate the degree and foreseeability of the disparate impact. Such data can show that it is foreseeable that a substantial number of individuals are adversely affected by the failure to provide language assistance in health care settings.[138]

Moreover, the Supreme Court has held that the availability of a nondiscriminatory alternative is evidence of discriminatory motive.[139] Here, such a discriminatory motive can also be inferred from the Title VI regulations, as well as the HHS Policy Guidance, which specifically require the implementation of less discriminatory alternatives than the exclusion of non-English speakers from medical services.[140] Such alternatives range from the provision of interpreters and written translations to the increased hiring and training of bilingual staff.[141] An analogy may be drawn to the provision of interpreters under the Americans with Disabilities Act where courts have been extremely reluctant to excuse a health care provider's failure to provide sign language interpreters under an "undue burden" defense. Health care providers will rarely

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137 HHS Policy Guidance, *supra* note 22, at 52, 762.

138 *See* Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J. L. & MED. 203, 223 (2001) ("Race and ethnic data reporting is the sine qua non of the effort to reduce racial and ethnic disparities in health care. Once reported, disparities become visible. Simply making the data public exposes the problem and creates a climate that encourages education, change and improvement.").

139 Albemarle Paper Co. v. Moody, 422 U.S. 405, 425 (1975).

140 HHS Policy Guidance, *supra* note 22, at 52,762. *See also* 45 C.F.R. § 80 et seq. (2001).

141 HHS Policy Guidance, *supra* note 22, at 52,762.

succeed in claiming that providing interpreting assistance for individuals with hearing impairments constitutes an undue burden because alternative accommodations, such as hiring interpreter employees in dual capacities, are feasible.[142]

Accordingly, non-English speakers should challenge their exclusion from meaningful access to medical services on equal protection grounds as purposeful discrimination with its several sub-factors. The fact that Title VI, as well as its implementing regulations and policies, are actually not formulated to exclude any particular group from access to services, but, to the contrary, contain an express anti-discrimination mandate, does not bar their consideration under the Equal Protection Clause. The Equal Protection Clause guarantees not only that similarly situated people will be treated similarly, but also that differently situated persons will be treated differently.[143]

In the case of non-English speakers, the latter is applicable. In their access to medical services, non-English speakers are not similarly situated to English-speakers because the health care system is administered only in English. Within this English-only context, a non-English speaker gains nothing from similar treatment (i.e. treatment in English) because communication, which ranges from scheduling an appointment to communicating with a physician, is rendered meaningless.[144]

Because language use by minority language groups has not yet been situated within the framework of legal standards that control the application of the Equal Protection Clause,[145] strict

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[142] Bonnie Poitras Tucker, *Health Care and the Americans With Disabilities Act: Access to Health Care for Individuals with Hearing Impairments*, 37 HOUS. L. REV. 1101, 1109 (2000) (including notes 43-46).

[143] Plyler v. Doe, 457 U.S. 202, 216 (1982) (noting that the Equal Protection Clause also prevents "things which are different in fact or opinion from being treated in law as though they were the same").

[144] HHS Policy Guidance, *supra* note 22, at 52,763 (noting that "in the course of its enforcement activities, OCR has found that persons who lack proficiency in English [LEP] frequently are unable to obtain basic knowledge of how to access various benefits and services for which they are eligible...For example, many intake interviewers are neither bilingual nor trained in how to properly serve an LEP person. As a result, the LEP applicant all too often is either turned away, forced to wait for substantial periods of time, forced to find his/her own interpreter who often is not qualified to interpret, or forced to make repeated visits to the provider's office until an interpreter is available in conducting the interview.").

[145] Smothers v. Dep't of Educ. of Puerto Rico, 806 F. Supp. 299, 305 (D. Puerto Rico

scrutiny would be inappropriate absent identification with national origin discrimination.[146] The Supreme Court has been unwilling to expand the categories of fundamental rights and suspect classes that would be protected by strict scrutiny.[147]

However, as the Court noted in *Smothers v. Department of Education of Puerto Rico*, there are laws which might impact upon important rights of language minorities which create serious equal protection problems without threatening a suspect class or fundamental right.[148] The Court then further suggests that laws which threaten rights like access to social services, which are not fundamental, yet important to the existence of a group in society, should be analyzed under an intermediate or "heightened" level of scrutiny, which requires substantial relation to an important government objective.[149] Thus, language classifications (including monolingual policies, as in the present case) need to be closely examined to see whether their effect unduly burdens any particular language group for impermissible reasons.[150] This is particularly so because English-only rules, whether de jure or de facto, typically have a disparate impact on the basis of national origin.[151]

In the medical context, the exclusion of non-English speakers from access to vital services through the failure to provide adequate language assistance unduly burdens that language group. At the same time, affording its residents access to health care services is an important governmental objective. The Supreme Court has a long history of valuing the importance of improving the health of its citizens. The advantages of a healthy populace are abundant: Healthy people enjoy a better quality of life, and are in a better position to contribute to society at large. They are also more productive in the work place. In addition, they are in a better position to participate in the political decision-making process, ensuring vindication of important political and social rights for all members of society.

1992).

146 *Id.* at 308.

147 Mass. Bd. of Ret. v. Murgia, 427 U.S. 319 at 319-320 (1976).

148 806 F. Supp. at 308.

149 *Id.*

150 *Id.* at 308-309.

151 *See, e.g.*, 29 C.F.R. § 1606.7(a) (EEOC Regulations) (noting that English-Only rules limit "opportunities on the basis of national origin").

Proponents of a monolingual provision of health care services usually point to the cost of providing interpreters as a justification for not altering the existing policies. The requirement to receive language assistance has been criticized by Medical Associations[152] and, in the worker's compensation system, by Self-Insurers Associations.[153] Thus, while the National Alliance for Hispanic Health, as well other groups (including the American Heart Association and the American Cancer Society) are asking for a strict enforcement of the provision of interpretation services, the AMA, all state medical societies and many doctor specialty groups are lobbying against an enforcement of the provision to supply interpreters due to cost.[154]

However, the courts have long recognized that economic considerations alone can never justify the deprivation of a constitutional right.[155] For instance, the Supreme Court has held that a concern for fiscal integrity is not a compelling justification for state welfare laws discriminating against resident aliens.[156] Similarly, administrative convenience is not a permissible justification for discriminatory practices.[157]

It is also worth noting that individuals with limited English proficiency contribute significantly to federally funded programs, as they comprise a large percentage of taxpayers in the U.S. To tax these individuals, yet at the same time deny them meaningful access to vital health care services in a system partially funded by their own economic contributions, is wholly at odds with the legislative intent of Title VI's anti-discrimination mandate. The legislative purpose of Title VI is to ensure "that the funds of the United States are not used to support racial discrimination"[158] and that "money collected by

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152 Erika Chavez, *Translator Rule a Burden, Doctors Say*, Sacramento Bee, October 9, 2000.

153 *Wilson's Vetoed Bills Return, Get a Slow Reception*, *supra* note 24.

154 Alexander Otto, *Lost in Translation: What's the Real Word On the Battle Over Doctor's Providing Interpreters?*, WASHINGTON POST, June 5, 2001 at T06.

155 *See, e.g.*, Owens-El v. Robinson, 442 F. Supp. 1368, 1373 (W.D. Pa. 1978). ("It is well established that an individual or class may not be deprived of constitutional rights simply because of economic considerations."). *See also* Rhem v. Malcolm, 507 F. 2d 333, 340 (2d Cir. 1974) (holding that "inadequate resources can never be an adequate justification for the state's depriving any person of his constitutional rights").

156 Graham v. Richardson, 403 U.S. 365, 375 (1971).

157 Frontiero v. Richardson, 411 U.S. 677, 690 (1973).

158 Statement by Sen. Humphrey, 110 Cong. Rec. 6544 (cited in Sandoval v. Hagan,

colorblind tax collectors will be distributed by Federal and State administrators who are equally color-blind."[159]

This, of course, is consistent with the HHS guidance, which considers it economically feasible to create a legal obligation to provide language assistance to non-English speakers in the health care context.[160] It is further consistent with the fact that publicly funded health care providers are usually unable to claim an undue burden defense if they fail to provide interpreters under the ADA, because state and local governments have resources available to cover such necessary expenses.[161]

The law has recognized in other areas that the mandatory provision of interpreters and other forms of language assistance is an important aspect of equal protection under the laws and meaningful participation in society at large. As early as 1889, the Supreme Court of Colorado recognized that the expense of providing an interpreter was outweighed by the importance of affording a Mexican elector the opportunity to serve on a jury.[162] Similarly, non-English speaking defendants are entitled to an interpreter in criminal proceedings.[163] And, as noted above, the ADA requires the provision of sign language interpreters in health care settings. [164]

Furthermore, the claimed fiscal savings by not providing language assistance may well be illusory.[165] Proper preventive care made available to non-English speakers through the provision of language assistance is in the long run less costly to society than allowing the condition to deteriorate to a point where much more expensive emergency hospitalization or care becomes necessary. As the Supreme Court noted in *Memorial Hospital v. Maricopa*, "lack of timely hospitalization and

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197 F.3d 484, 498 (11th Cir. 1999)).

159 110 Cong. Rec. 7054 (1964), Statement by Sen. Pastore (cited in *Hagan*, 197 F.3d at 498 (11th Cir. 1999)).

160 Allen, *supra* note 4, at S1 (noting that the director of the Office for Civil Rights at the U.S. Department of Health and Human Services charged with overseeing and reviewing language discrimination in health care settings has stated that "the federal government has a lot of money potentially available to states for interpreting services," provided they comply with their obligation to provide such services). *Id.*

161 Tucker, *supra* note 142, at 1108.

162 *In re* Allison, 22 P. 820, 822 (Colo. 1889).

163 Alice J. Baker, *A Model Statute to Provide Foreign-Language Interpreters in the Ohio Courts*, 30 U. TOL. L. REV. 593, 599 (1999).

164 Tucker, *supra* note142, at 1108.

165 Memorial Hosp. v. Maricopa County, 415 U.S. 250, 265 (1974).

medical care for those unable to pay has been considered an economic liability to the patient, the hospital and to the community in which these citizens might otherwise be self-supporting."[166]

Similarly to uninsured individuals, whose greater risk of health problems could be avoided through preventive care,[167] non-English speakers would be able to benefit from preventive care if adequate language assistance were provided. This, in turn, would free up urgent care services for those emergencies that cannot be avoided through preventive care.[168]

Additionally, the provision of timely language assistance also reduces the cost of malpractice suits, which would otherwise further financially burden the medical system.[169] Thus, it is actually less costly to use seemingly expensive interpreter services than to face malpractice suits for failure to provide non-English speaking patients with access to services equal to those provided to English speakers.[170] Following such a lawsuit, the University of California at San Francisco, which is one of the three top-ranking research hospitals in the U.S., for instance, developed an in-house interpreter services department and other means to provide adequate language assistance.[171] This did not only contribute to better patient services and satisfaction, but also increased its revenues.[172]

Those who oppose the provision of governmentally provided translation services have also argued that there is no principled way to decide what foreign languages should be accommodated.[173] Further, opponents argue that since foreign language assistance cannot possibly be provided in all languages, it should not be provided at all.[174] These arguments are unimpressive.

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166 *Id.*

167 Duffy & Alexander, *supra* note 11, at 507.

168 Kimberly Hayes Taylor, Better *Services for Immigrants*, MINNEAPOLIS STAR TRIBUNE, January 4, 2000, at 1B.

169 *See, e.g.*, Scioscia, supra note 5.

170 Duffy & Alexander, supra note 11 at 507.

171 *Id.*

172 *Id.*

173 Sandoval v. Ala.Dep't of Pub. Safety, 7 F. Supp. 2d 1234, 1303 (M.D. Ala. 1998), *rev'd by Sandoval*, 532 U.S. 275. *See also* Mona T. Peterson, *The Unauthorized Protection of Language under Title VI*, 85 MINN. L. REV. 1437, 1468 (May 2001).

174 *Sandoval*, 7 F. Supp. 2d at 1304, *rev'd by Sandoval*, 532 U.S. 275.

As the District Court recognized in *Sandoval*, the fact that there may be a handful of people whose languages are too rare to accommodate is not a reason to refuse to serve the thousands of persons whose languages are common in the state.[175] In doing so, the court noted that 95% of language assistance requests were confined to the most prevalent languages in the state.[176] This is wholly compatible with the HHS Policy Guidance, as well as state laws, such as the Bilingual Services Act, which tie their obligation to provide language assistance to the proportion of non-English speakers in a given area.[177] Conversely, it is precisely the exclusion of a substantial number of non-English speakers by a monolingual health care system that creates discrimination with a strong disparate impact.

Therefore, the cost of providing interpreters does not substantially relate to an important governmental objective that would justify eliminating language assistance to non-English speakers in their access to health care services. At the same time, the provision of such interpreting and translation services does further an important right (access to vital health services) and an important governmental objective, namely a healthy population able to participate meaningfully in society at large. Thus, in light of *Sandoval*, the exclusion of non-English speakers from essential medical services may be advanced through private action under an equal protection analysis.

B. OTHER AVENUES TO CHALLENGE LANGUAGE DISCRIMINATION IN MEDICAL SETTINGS

Aside from an equal protection challenge, language discrimination in medical settings should also be challenged on other fronts. As the dissent in *Sandoval* suggests, a violation of regulations adopted pursuant to Title VI may be established by proof of discriminatory impact in a Section1983 action against

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[175] *Id.*

[176] *Id.*

[177] *See* BUREAU OF STATE AUDITS, CALIFORNIA STATE AUDITOR, supra note 80, at 1-2; HHS Policy Guidance, *supra* note 25, at 52,766 (noting that the requirement to provide language assistance under Title VI depends on the size of the LEP population and the frequency with which particular languages are encountered).

state actors.[178] A Section1983 action allows individuals to sue state, local and federal governmental agencies for violations of either the federal constitution or any federal law.[179] However, such suits may not extend to private organizations whose receipt of federal funds would bring them under Title VI.[180] Thus, even though an important tool in forcing publicly funded health care centers to provide the necessary language assistance, Section 1983 may not create legal obligations for privately funded health clinics that do participate in federally funded programs, such as Medicaid. A more detailed discussion of Section 1983 is, however, outside the scope of this article.

Language access claims brought under alternative statutory provisions and raised in a variety of analogous settings should be coupled with outreach work to increase awareness of the issue, such as informing individuals of their rights and legal recourse. Advocacy work to raise funds for the provision of interpreters and continuing education will also be important. Lastly, pressuring the legislature to amend and refine existing statutes and ordinances, as well as affecting the judiciary through impact litigation will similarly advance the right to language assistance in medical settings.

CONCLUSION

The denial of non-English speakers' access to medical services is analogous to other forms of language discrimination, such as that found in the employment and education context. As these parallel cases and recent legislative efforts demonstrate, existing laws should be interpreted and expanded

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[178] *Sandoval*, 532 U.S. at 301, footnote 6 (Stevens, J., dissenting). 42 U.S.C. § 1983, allowing lawsuits against state, local and federal government agencies that violate either the federal Constitution or any federal laws. It provides, in its relevant part that:

> ...every person who, under color of any statute, ordinance, regulation, custom or usage of any State or Territory or the District of Columbia subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity or other proper proceeding for redress....

Id.

[179] Hodge v. Jones, 513 U.S. 1018 (1994)(holding that if there is no violation of a federal right, there is no basis for a civil rights action under § 1983).

[180] SUPREME COURT BLUNTS CIVIL RIGHTS, *supra* note 39.

to include a protection within health care settings. Furthermore, since in light of *Sandoval* the private right of action to bring a disparate impact Title VI case has been eliminated, equal protection arguments should be advanced. This is particularly compelling because medical care is a vital service, which should fall within the ambit of the Equal Protection Clause. Such equality translates into providing individuals of limited English proficiency with the same medical treatment that English-speakers enjoy.

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