
Overcoming Language Barriers to Health Care

JANE PERKINS

Overcoming language barriers to health care is critical to the well-being of millions of immigrants in the United States today. About 32 million people in this country, 13.8 percent of the population, speak a language other than English at home.¹ The health care delivery system is hard-pressed to handle this diversity. Health care providers in major cities and in West Coast states, in particular, deal with an amazing variety of languages and cultures. For example, in the first four months of 1993, Kaiser Hospital in Oakland, California, provided translation services in Amharic, Arabic, Cambodian, Cantonese, Chouchou, Hungarian, Ilocano, Italian, Japanese, Korean, Laotian, Mandarin, Romanian, Russian, Spanish, Tagalog, Tigrinya, Toishanese, and Vietnamese.²

Although more pronounced in urban and western areas, dramatic increases in the number of residents with limited English proficiency (LEP) are occurring nationwide. North Carolina itself is experiencing an unprecedented influx. A growing number of the state's residents are from Bosnia, Central American countries, China, Laos, Mexico, and Vietnam. An accurate count of



Photo by Robert Miller

The author is director of legal affairs at the National Health Law Program and an adjunct professor in UNC-CH's School of Social Work. The author's work on this article was supported by a grant from the Henry J. Kaiser Family Foundation, Menlo Park, California. Opinions are those of the author and do not necessarily reflect the views of the foundation.

LEP speakers in the state is difficult to obtain, but it is estimated that there are between 250,000 and 300,000 Spanish speakers alone.

Communication barriers complicate the delivery of health care. The following recent accounts illustrate the problem:

- In central North Carolina, Hispanic residents have complained that they must wait longer than non-Hispanic residents to receive treatment from the local health department. When these residents do receive care, family members or unqualified health department employees translate during the visit, or they are asked to pay for each fifteen minutes of interpreting.
- In central North Carolina, a hospital used a child to translate during his parent's emergency room visit. As the boy and his parent left the facility, another LEP family arrived with an emergency. The boy had to translate during that visit as well.
- In South Carolina a hospital limited epidural anesthesia for women in labor to women who could speak English.

This article addresses the need for translation services during health care visits and the ways in which these needs are most frequently met. It describes the factors inhibiting appropriate linguistic access, then provides an overview of the laws governing linguistic access to health care. The article closes with some recommendations for making care more linguistically accessible.

THE NEED FOR TRANSLATION SERVICES

Patients who do not speak English need qualified interpreters to describe potentially complex medical problems and treatment plans. Words that English-speaking patients may use, such as "hypertension" or "allergies," often do not have equivalents in other languages. Further, communicating subtle distinctions can be very important. As one California doctor explains, "The difference between 'crushing pain' when the patient is walking and 'sharp pain' can mean the difference between severe coronary artery disease and gastritis [stomach inflammation]."³

Translation of a medical visit by unqualified interpreters is prone to omissions, additions, substitutions, volunteered opinions, and semantic errors that can seriously distort care.⁴ In one study, analysis of recorded encounters during which an adult son interpreted for his Russian father demonstrated incorrect

translation of more than 28 percent of words and phrases.⁵

In addition, the use of untrained interpreters can result in a breach of patient confidentiality. Reliance on interpreters who are not trained in the ethics of interpretation can cause a patient not to speak freely in front of a health care provider, especially when children are translating for parents about such sensitive issues as spousal abuse and sexual practices.⁶

The lack of appropriate translation services also affects the cost of care. Non-English-speaking patients may be reluctant to deal with providers who cannot communicate with them, seeking care only when their conditions become acute and more costly. Fifty-eight percent of LEP patients polled by the Asian Health Services in 1994 reported that they would not see a physician if interpreting services were not available.⁷ Further, to fill the gaps created by the language barrier, doctors may turn to batteries of expensive, often unnecessary tests. One study found that language differences caused treatment of non-English-speaking patients to take 25 to 50 percent longer than treatment of English-speaking patients.⁸ Finally, inadequate interpreting has been shown to delay a correct diagnosis and to increase the chances that the patient will not be able to follow the doctor's orders.⁹

Unfortunately, translation needs often go unmet or are handled inappropriately in health care settings. Many hospitals and clinics do not have qualified interpreters on hand. Rather, they rely on family, friends, or untrained staff, or they allow providers to deliver services without any verbal communication with the patient. Important medical information typically delivered to patients in writing—for example, informed-consent forms and discharge treatment plans—may be provided only in English.¹⁰

FACTORS INHIBITING LINGUISTIC ACCESS

A number of state and federal laws (discussed later) address provision of translation services to LEP patients.

NORTH CAROLINA RESOURCES

N.C. Office of Minority Health
(919) 715-0992

N.C. Bilingual Resource Group
(919) 715-3119

Hispanic Ombudsman, Office of
Citizen Services, N.C. Department
of Health and Human Services
(919) 733-4261

AT&T Language Line
1-800-821-0301
(demonstration and information)

Nonetheless, linguistic access is not well developed. Several factors create barriers.

First, the number of different languages spoken in the United States has grown dramatically in the last thirty years. Today, hundreds of languages are spoken in both urban and rural areas.¹¹ The trend will continue. Estimates are that by 2010 the U.S. minority population will have increased by 60 percent and will include immigrants from all around the world.

Second, translation services cost money, and current levels of funding are inadequate. States and health care providers have been slow to bill Medicare and Medicaid for the administrative costs associated with providing language services. Also, recent federal laws regarding immigrants have created confusion about the extent of providers' obligations to serve LEP populations. Federal law now makes many immigrants ineligible for significant public benefits, including Medicaid, during their first five years in the country or altogether.¹² The loss of federal Medicaid funds is particularly stressful to public hospitals and clinics, on which many immigrants rely. Moreover, many health care providers are uncertain about the extent to which they can and should provide health care, including translation services, to immigrant populations. (For more discussion of these issues, see "Immigrants' Access to Public Benefits: Who Remains Eligible for What?," page 22 in this issue.)

Third, there often is little public support for the affected minority groups. In a 1996 poll by The University of North Carolina at Chapel Hill's School of Journalism, nearly half of those surveyed (42 percent) stated that they were uncomfortable with the growth of the Hispanic population in North Carolina, and more than half (55 percent) said that they did not feel comfortable around people who do not speak English. (For an in-depth review of this poll, see "A Profile of Hispanic Newcomers to North Carolina," page 2 in this issue.)

Finally, although there are state and federal laws requiring access to linguistically appropriate health care, they are largely unused in practice. The remainder of this article discusses these laws.

LINGUISTIC ACCESS PROVISIONS AND POLICY DEVELOPMENT IN NORTH CAROLINA

North Carolina is just beginning to develop legal requirements for linguistic access in health care settings. For its Medicaid managed-care program, the state's Division of Medical Assistance uses contracts that specifically address linguistic access. These contracts

require the managed-care plans that are contracting with the state Medicaid agency to comply with Title VI of the Civil Rights Act (which, as discussed later, prohibits discrimination on the basis of national origin); to provide marketing materials in English, Spanish, and other needed languages; and to make interpreter services available 24 hours a day by telephone and/or in person, to ensure that plan members can communicate with plan personnel and their providers.¹³

There also is activity at the policy development stage. Governor James B. Hunt, Jr., has appointed an Advisory Council on Hispanic/Latino Affairs, which, among other activities, is investigating ways to improve the provision of health care services to LEP patients. At the local level, the North Carolina Association of Local Health Directors has passed a resolution recognizing the critical need for interpreter services, particularly for the fast-growing Hispanic population, and asking local public health agencies to take a lead role in communicating with the public about the importance of providing linguistic access and complying with Title VI of the Civil Rights Act.¹⁴

On another legal front, failure to provide translation during health care visits may violate the laws of informed consent. A health care provider's failure to obtain informed consent is a basis for a lawsuit in North Carolina, originally grounded in common law¹⁵ but also addressed in statute.¹⁶ Generally, to establish a failure to secure informed consent, a person must show that (1) the provider failed to inform the patient of a material fact relating to treatment; (2) the patient consented to the treatment without being aware of that fact; (3) a reasonable patient under similar circumstances would not have consented if given such information; and (4) the treatment in question caused injury to the patient. A signed form creates a presumption that a consent is valid;¹⁷ however, inability to read the form might overcome that presumption.¹⁸ Although a North Carolina court has not ruled on the issue in any reported decision, courts in other jurisdictions have found language barriers to give rise to claims that the physician failed to obtain a patient's informed consent.¹⁹

LINGUISTIC ACCESS PROVISIONS IN FEDERAL LAW

Although North Carolina has only recently begun to develop specific policies and legal requirements regarding linguistic access in health care settings, a number of federal laws and regulations require health care providers in North Carolina to ensure linguistic access.²⁰

Title VI of the Civil Rights Act

Congress passed Title VI of the Civil Rights Act to ensure that federal money is not used to support discrimination on the basis of race or national origin in government activities, including the delivery of health care. Title VI states, “No person in the United States shall, on 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.”²¹ Taken together, Title VI and its implementing regulations bar both intentional discrimination and activities that have a disparate discriminatory impact based on race, color, or national origin—even when the recipient of federal funds does not have an actual intent to discriminate.²²

In the thirty years since the Title VI provisions became law, federal subsidy of health care has become pervasive, causing the numbers of providers and entities that must comply with Title VI to skyrocket. (Generally, providers who bill Medicare or Medicaid or receive other federal funds must comply with Title VI.) When Title VI is violated, expansive remedies may be authorized, including injunctive relief, corrective action plans, termination of federal funds, and possibly the award of damages.

Neither Title VI nor the implementing regulations discuss linguistic access per se. However, courts have consistently found a close connection between national origin, which is specifically covered by Title VI, and language. In *Lau v. Nichols*, the U.S. Supreme Court held that the San Francisco school system violated Title VI by failing to take steps to assist LEP Chinese students: “It is obvious that the Chinese-speaking minority receive fewer benefits than the English-speaking majority from respondents’ school system which denies them a meaningful opportunity to participate in the educational program—all earmarks of the discrimination banned by” the Title VI regulations.²³ Since *Lau*, a number of lower courts have found that the failure to provide translation services may be discrimination on the basis of national origin.²⁴

In addition, the U.S. Department of Health and Human Services’ Office for Civil Rights (OCR) has consistently found that recipients of federal funds have an obligation under Title VI to communicate effectively with LEP people. As recently as last year, the agency reiterated that “where language barriers cause persons with limited English proficiency to be excluded from or be denied equal access to health or so-

cial services, recipients may be required to take steps to provide language assistance to such persons.”²⁵ This statement reflects the position taken by OCR over the last decade, in more than 100 administrative decisions and compliance agreements affecting individual health care providers. These OCR decisions articulate the following basic requirements:²⁶

1. Recipients of federal funds should have a written policy for linguistic access and should make sure that staff are aware of the policy.
2. Recipients of federal funds should have a procedure for offering translation services to LEP patients during all hours of operation.
3. Family and friends should be allowed to interpret only after a patient has been informed of the availability of the services of a qualified interpreter at no cost to the patient.
4. Minors should not be used to translate.
5. “Qualified” interpreters should have demonstrated bilingual proficiency and knowledge of medical terms and of the ethics of medical interpreting.
6. The use of telephone translation services should be limited to situations in which no bilingual staff person or qualified interpreter is available to provide services.
7. Important medical documents should be translated for the patient.

The Hill-Burton Act

The Hill-Burton Act, another federal law that bears on linguistic access to health care, encourages construction and modernization of public and nonprofit community hospitals, health centers, and nursing homes.²⁷ Although the act benefits communities nationwide,



Father and child await their turn in a public health clinic, beneath a sign in Spanish telling parents about Medicaid procedures for their children’s checkups.

Photo by Susan Simone



Photo by Chris Johnson

As a woman gets an eye checkup, her child eyes the photographer.

health care facilities in the South have made heavy use of Hill-Burton funds.

In return for Hill-Burton support, facilities agree to be bound in perpetuity by provisions requiring “community service.” Facilities must make services “available to all persons residing . . . in the facility’s service area without discrimination on the ground of race, color, national origin, creed or any other ground unrelated to an individual’s need for service or the availability of the needed service in the facility.”²⁸ OCR has consistently taken the position that the community service obligation requires hospitals to address the needs of LEP patients.²⁹ Past OCR administrative remedies have included requirements that hospitals and nursing homes develop lists of bilingual interpreters, establish procedures for communicating with LEP patients at all hours of a facility’s operation, and notify patients that interpreter services are available.³⁰

Federal Block Grant Programs

The secretary of Health and Human Services makes grants to public and private nonprofit entities to plan, develop, and operate community health centers serving medically underserved populations and areas suffering shortages of health care personnel.³¹ Grant monies also are given to public and private nonprofit clinics serving migratory agricultural workers, seasonal agricultural workers, and their families. If a substantial number of patients with limited English proficiency are in a service area, federal law requires migrant

health centers and community health centers to provide linguistically and culturally appropriate services and outreach.³² Similarly, federally funded alcohol abuse centers must use language-appropriate outreach workers and identify employees who are able to translate full-time.³³

Protections against “Patient Dumping”

The Emergency Medical Treatment and Active Labor Act (EMTALA) protects patients against “dumping.” That is, it generally requires all hospitals that participate in Medicare and have an emergency department to treat any patient in an emergency condition, regardless of the patient’s ability to pay. A violation of EMTALA occurs (1) when a hospital does not adequately screen a patient to determine whether an emergency exists or (2) when a hospital discharges or transfers a patient (a) without informed consent before his or her condition is stabilized or (b) without certifying that, based on information available at the time, the medical benefits of transfer outweigh the risks involved.³⁴

The extent to which EMTALA requires language-appropriate health care is largely untested. At the very least, issues arise with respect to EMTALA’s requirements for informed consent and transfer. For example, the language barrier may be so severe that it is impossible for emergency room personnel to communicate effectively with a patient and obtain the patient’s informed consent for transfer. It is less clear, however, whether EMTALA mandates language-appropriate screening, and to date, no court has looked at this question. Courts have ruled that EMTALA may be violated if a patient demonstrates that the screening examination he or she received was not as thorough or careful as that which the hospital typically provides.³⁵ This reasoning might support a finding that EMTALA is violated by failure to provide translation services that allow the emergency room doctor to communicate with a conscious patient and allow the patient to understand the outcome of the screening.

CONCLUSION AND RECOMMENDATIONS

La ley no es silenciosa—the law is not silent—on provision of linguistically accessible health care, but to date, enforcement has been spotty. As more LEP patients face the prospects of receiving delayed or inappropriate care or failing to understand the health care options available to them, health care providers confront increasing risks if they do not provide accessible care. A number of steps might be taken to make care more linguistically accessible.

First, medical and provider associations, state offices, and community-based organizations should educate the health care community about the laws that require provision of linguistically accessible health services and about the potential consequences of failing to adhere to these laws.

Second, policy makers should provide top-down clarity that these legal protections are important and should be recognized.

Third, the research community might assess the benefits and the net costs of providing linguistically accessible health care and articulate ways of providing this care economically.

Fourth, consumers and their representatives, health plans and providers, foundations, and policy makers might experiment with programs designed to overcome linguistic and cultural barriers. This already is occurring in some areas. For example, hospitals in Seattle are banding together to contract with on-call interpreter pools. Clinics across the country are working with community organizations to identify bilingual residents who can be trained as volunteer translators. Higher education institutions, such as New York's Hunter College, are teaching students to serve as professional-level interpreters for college credit.³⁶ In Oakland, California, Asian Health Services has trained community residents in interpretation skills and offered their services to local hospitals and community clinics.³⁷ In North Carolina, the Duke Endowment has funded the state's Office of Minority Health and the state's Area Health Education Centers Program to establish the Spanish Language and Cultural Training Institute, which is sponsoring statewide training for interpreters working in health and human service settings.³⁸

Finally, health care consumers and consumer organizations might document problems with obtaining accessible care; report the problems to the affected providers and civil rights enforcement agencies; and participate in community-based efforts to resolve the problems.

NOTES

1. Bureau of the Census, Economics & Statistics Administration, *Selected Social Characteristics: 1990* (Washington, D.C.: 1990), table 1.

2. John Flinn, "Californians Talk in Most Languages of All: Its People Speak 224 Languages, 40 More than in N.Y.," *San Francisco Examiner*, April 28, 1993, p. A1.

3. Marilyn Lewis, "Translators Provide a Critical Link for Foreign-Born Patients," *San Jose Mercury News*, Nov. 25, 1988, p. 1A (quoting Dr. Kent Imai, chief of the Department of Medicine's Primary Care Division at California's Valley Medical Center).

4. See D. W. Baker et al., "Use and Effectiveness of Interpreters in an Emergency Department," *JAMA* 275 (Mar. 13, 1996): 783-88; Steven Woloshin et al., "Language Barriers in Medicine in the United States," *JAMA* 273 (Mar. 1, 1995): 724-28.

5. Bruce T. Downing, "Quality in Interlingual Provider-Patient Communication and Quality of Care" (manuscript, Sept. 1995), 7-9 [available from the Kaiser Family Foundation, Menlo Park, Calif., (800) 656-4533].

6. See, e.g., Linda Hafner, "Translation Is Not Enough: Interpreting in a Medical Setting," *Western Journal of Medicine* 157 (Sept. 1992): 255-59.

7. Emily Friedman, "Language, Culture and Care" (manuscript, Sept. 1995), 32 [available from the Kaiser Family Foundation, Menlo Park, Calif., (800) 656-4533].

8. Mark M. Hagland, "Crossing Cultures: Hospitals Begin Breaking Down the Barriers to Care," *Hospitals* 67 (May 20, 1993): 29.

9. See, e.g., Woloshin et al., "Language Barriers in Medicine," 724; A. Manson, "Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma," *Medical Care* 26 (1988): 1119-28.

10. National Health Law Program, "Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities" (manuscript, Jan. 1998), 7-18 [available from the Kaiser Family Foundation, Menlo Park, Calif., (800) 656-4533].

11. U.S. Department of Health and Human Services, Office for Civil Rights, *Limited English Proficiency as a Barrier to Health & Social Services* (prepared by Macro International, Inc.) (Washington, D.C.: 1995), 3.

12. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

13. North Carolina Division of Medical Assistance, *Contract for Services between the State of North Carolina, Division of Medical Assistance and _____, a Health Maintenance Organization* (Raleigh: 1997-98). The state also has entered into one or more contracts with local health departments, that require them to provide interpreter services at no cost to patients for health care services provided free to the general public. See North Carolina Division of Medical Assistance, *Consolidated Contract between State of North Carolina and Local Health Department for the Purpose of Maintaining and Promoting the Advancement of Health in North Carolina (July 1, 1998, to June 30, 1999)* (Raleigh:

NCDMA, 1998). As noted later, such provisions should be reviewed against the Title VI guidance issued by the federal Office for Civil Rights. See note 25.

14. North Carolina Association of Local Health Directors, Policy and Planning Liaison Committee, *Resolution on Language Services in Public Health* (Raleigh: NCALHD, Jan. 14, 1998) [available from North Carolina Office of Minority Health, Raleigh, (919) 715-0992].

15. See *Hunt v. Bradshaw*, 242 N.C. 517, 88 S.E.2d 762 (1955) (holding that failure to explain risks involved in surgery may be considered mistake on surgeon's part). *Hunt* is cited as one of the U.S. cases that marked the transition from simple consent to the contemporary concept of informed consent. See Paul S. Appelbaum, Charles W. Lidz, and Alan Meisel, *Informed Consent: Legal Theory and Clinical Practice* (New York: Oxford University Press, 1987), 38.

16. N.C. Gen. Stat. § 90-21.13 (hereinafter G.S.).

17. G.S. 90.21.13(b).

18. See *Estrada v. Jaques*, 70 N.C. App. 627, 321 S.E.2d 240 (1984) (holding that signed form is not conclusive when adequacy of underlying representations is disputed); *Snyder v. Ash*, 596 N.E.2d 518 (Ohio Ct. App. 1991) (holding that signing of informed-consent form does not have presumptive validity if plaintiff shows "that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written").

19. See generally *Rosario v. United States*, 824 F. Supp. 268 (D. Mass. 1993) (ruling against Spanish-speaking patient when hospital provided Spanish-speaking doctor, and plaintiff failed to demonstrate that doctor withheld any information reasonably necessary to make informed decision).

20. This article does not discuss legal requirements for linguistic access that apply to the state Medicaid agency, county Medicaid offices, and agents of the state Medicaid agency. For a discussion of these provisions, see National Health Law Program, "Ensuring Linguistic Access."

21. 42 U.S.C. § 2000d.

22. "A recipient . . . may not . . . utilize criteria or methods of administration which have the effect of subjecting individuals 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." 45 C.F.R. § 80.3(b)(2) (emphasis added). See also *Guardians Ass'n v. Civil Serv. Comm'n of N.Y.*, 463 U.S. 582 (1983).

23. *Lau v. Nichols*, 414 U.S. 563, 568 (1974); see also 414 U.S. at 570-71 (Stewart, J., concurring in result).

24. See, e.g., *Odima v. Westin Tuscon Hotel Co.*, 991 F.2d 595, 601 (9th Cir. 1993) ("accent and national origin are obviously inextricably intertwined"); *Garcia v. Gloor*, 618 F.2d 264, 270 (5th Cir. 1980) ("To a person who speaks only one tongue or to a person who has difficulty using another language than the one spoken in his home, language might well be an immutable characteristic like skin color, sex or place of birth"); *Sandoval v. Hagan*, 7 F. Supp. 2d 1234, 1280-82 (M.D. Ala. 1998) (noting that "the multitude of cases that find a strong nexus between language and national origin" support a holding that English-only drivers'

license tests violate Title VI); *Asian Am. Business Group v. City of Pomona*, 716 F. Supp. 1328 (C.D. Cal. 1989) (holding that ordinance restricting use of foreign languages on business signs "overtly discriminates on the basis of national origin"); *Hernandez v. Erlenbusch*, 368 F. Supp. 752 (D. Or. 1973) (finding that tavern's rule against speaking foreign languages amounted to racial discrimination against Mexican Americans).

25. Office for Civil Rights, *Title VI Prohibition against National Origin Discrimination—Persons with Limited English Proficiency* (Jan. 1998), available at <http://www.hhs.gov/progorg/ocr/lepfinal.htm>.

26. National Health Law Program, "Ensuring Linguistic Access," app. D.

27. 42 U.S.C. § 291.

28. 42 C.F.R. § 124.603.

29. Office for Civil Rights, *Guide to Planning the Hill-Burton Community Service Compliance Review* (Washington, D.C.: 1981), 16, 27.

30. See, e.g., *Saddleback Community Hosp.*, No. 09-87-8001 (OCR compliance agreement, Nov. 10, 1987); *Children's Orthopedic Hosp.*, No. 10813023 (OCR memorandum agreement, Oct. 6, 1981) [available from National Health Law Program, Los Angeles, Calif., (310) 204-6010].

31. 42 U.S.C. § 254c.

32. These centers must provide "services to the extent practicable in the language and cultural context most appropriate to such individuals" and must identify staff "fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences." 42 U.S.C. §§ 254b(f)(3)(J), 254c(e)(3)(J).

33. 42 U.S.C. § 4577(b)(3).

34. 42 U.S.C. § 1395dd. EMTALA prohibits the transfer of a patient in an emergency medical condition unless (1) the patient provides his or her informed consent or a physician (or a qualified medical person working under the supervision of a physician) certifies that the benefits of transfer outweigh the risks; and (2) the transfer is appropriate. A patient has not given informed consent unless the patient consents in writing "after being informed of the hospital's obligations under [EMTALA] and of the risk of transfer." For a transfer to be "appropriate," the sending hospital must verify that the receiving hospital has both available space and qualified personnel for the treatment of the patient and that it agrees to accept the transfer and provide appropriate medical treatment. 42 U.S.C. § 1395dd(c)(2).

35. See generally *Brooks v. Maryland Gen. Hosp.*, 996 F.2d 708 (4th Cir. 1993).

36. William Douglas, "Many Tongues Spoken, Students Translate at Clinics & Hospitals," *Newsday*, Jan. 3, 1993, p. 39.

37. Linda Okahara, director, Language and Cultural Access Program, Asian Health Services, interview with the author, Jan. 17, 1995.

38. North Carolina Area Health Education Centers, *Spanish Language and Cultural Training Initiative Informational Bulletin* (Raleigh: Aug. 1998).