The National Council on Interpreting in Health Care
Research Reports Series

Remote Interpreting Modalities in Health Care Settings: Insight from Interpreters

This report was written by members of the NCIHC Research Work Group, which operates as part of the Policy, Education, and Research Committee: Gabriela Espinoza Siebach, Jaime Fatas, Linda Golley, Michelle Scott, and Eva Stitt. This report presents data from a 2021 64-item survey that had the intent of understanding the impact of the COVID-19 pandemic on language access in healthcare through the experience of healthcare interpreters.

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Introduction

The National Council on Interpreting in Health Care (NCIHC) is a multidisciplinary organization whose mission is to promote and enhance language access in health care in the United States. One of its goals is to develop and monitor policies, research, and best practices. The recent pandemic created a different landscape locally, nationally, and internationally, and healthcare interpreters have had to adapt and adjust to help themselves and the communities that rely on them for support.

In 2021, the NCIHC issued a survey for healthcare interpreters. Although the overarching goal of this study was to understand the impact of the COVID-19 pandemic on language access in health care in the United States through the experience of interpreters, the responses provided insights into remote interpreting modalities.

The feedback received from respondents in relation to remote modalities of interpreting is presented in this paper. The survey consisted of 64 questions. The analysis and interpretation of the data presented here are limited to Questions 18–20 and 40–47 only.

Analysis

The majority of respondents indicated that the modality in which they interpreted had changed since the onset of the pandemic, with the vast majority noting an increase in remote modalities (including telephone, video, and either telephone or video telemedicine), which was an expected result, as in response to the pandemic the CDC recommended the use of telehealth when appropriate (CDC, 2020).

In relation to challenges and issues faced in remote modalities since the onset of the pandemic, the most common challenges included the use of masks or ventilators hindering communication and the provider or staff speaking in a manner that is difficult to understand. Additionally, in relation to challenges with the reliability of the equipment or the internet connection, the majority of respondents indicated that they experienced problems. The most common problems reported were problems with the internet connection and problems with background noise at the patient end. Considering that message reception (hearing the message) is the first stage for interpretation and that challenges to hearing the message will affect subsequent stages in the interpreting process (Cokely, 1992), the high number of respondents that reported challenges in this initial stage is meaningful. Another issue commonly encountered during remote interpreting was a lack of briefing about issues related to the medical situation.

Survey responses also indicate that interactions have been impacted by remote interpreting as a result of COVID-19; many respondents noted that, in their opinion, the rapport between the provider and the patient had been affected, which merits further investigation, as early pioneer studies have shown a correlation between provider–patient rapport and health outcomes (Leach, 2005). Respondents also indicated that, in their opinion, accuracy may have been affected. Both findings merit further investigation and measurement to understand whether the perception of the interpreter is based on their COVID-induced stress or on actual changes in accuracy and/or rapport.

Responses also confirm previous studies, conducted prior to the COVID-19 pandemic, that found that interpreters are more likely to prefer on-site encounters to telephone or video interpreting encounters (Locatis et al., 2010) and that there is a preference for video over

telephone interpreting (Lion et al., 2015) when a remote modality is needed or required, as has been the case during the COVID-19 pandemic. In relation to interpreters' response to modality changes since the onset of COVID-19, most respondents reported that they have learned to adapt and adjust to remote interpreting as they take assignments, and only a few reported being hesitant to accept remote interpreting assignments because they lacked the skill or the technology.

Communication between healthcare providers and English-speaking hearing patients was negatively impacted by COVID-19 conditions. These same conditions had an even greater negative impact on interpreted interactions. Further investigation on such effects of COVID-19 on healthcare language access is required.

What Do We Want to Know More About? (Hint: Please do this research!)

- Experience of the *three* members of the triad (patients, care team, interpreters) in interpreted sessions *during COVID-19*, comparing perception to actual quality of communication.
- Bigger sample size of interpreters, maybe better spread over geographic locations, language groups, or types of encounter environments (surgical, specialty, procedure, inpatient, ER, clinic, etc.)
- Extension of these same questions of challenges and adaptation *over time* as remote interpreting becomes a more commonly used modality. For new interpreters coming into the field, do they perceive challenges similar to those described by the interpreters who answered the first NCIHC survey about changes to interpreting experience during COVID-19?
- *Patient perception* of remote interpreting modalities, given COVID-19. Do they miss the many forms of emotional, social, and navigation support provided by on-site interpreters, if they had ever experienced that? Do they appreciate the privacy of having a remote interpreter from some other place rather than a local on-site interpreter? To what extent do patients just go quiet when the interpreter is remote, for whatever reason (such as confusion, inability to hear, shyness to speak up for the interface, etc.)?
- *Provider perception* of remote interpretation modalities, given COVID-19. What do providers say about whether they have had to switch from on-site to remote interpreter availability, and if they did, did they have challenges and what kinds of challenges, better availability, etc.? Have providers learned how to partner with their interpreters to verbalize what they are doing so that the interpreter does not have to guess? Have providers learned to enunciate more clearly through their mask, to do a teach-back to check that the patient has understood them? How have providers compensated for the lack of an on-site interpreter to assist patients with filling out forms?

As true telehealth becomes a more established way for care teams to interact with patients, in other words, the patient and provider are *not* in the same building as each other:

- What do we know about the percentage of time an interpreter is included as the third point in the triad?
- Is the digital nature of telehealth simply not accessible to most language-need patients, or to some segments of the non-English-speaking patient population more than to others?
- When an interpreter *is* included in the telehealth encounter, what challenges are there for the interpreter to manage optimal communication with all parties over three locations?

Background

For the millions of Limited-English-Proficient (LEP) individuals living in the United States, language can be a "barrier to accessing important benefits or services, understanding and exercising important rights, complying with applicable responsibilities, or understanding other information provided by federally funded programs and activities" (U.S. DOJ, 2002, p. 41457). Title VI of the Civil Rights Act of 1964 and other subsequent legislation require healthcare providers who receive federal funds to offer meaningful access to individuals with limited ability to read, write, speak, or understand English, generally called LEP individuals (U.S. DOJ, 2002).

In 2016, a job task analysis survey conducted by the Certification Commission for Healthcare Interpreting (CCHI) indicated that 88% of respondents (n = 1,525) reported that their primary modality of interpreting was in-person.

Accurate and effective interpretation contributes to eliminating health care disparities, increasing patient engagement, providing accurate diagnosis, enhancing treatment plan compliance, and improving overall health outcome for the LEP patient (Hassan, 2020).

Even though many interpreters were able to continue working during the pandemic thanks to remote interpreting, video interpreting had already introduced specific barriers to communication prior to the pandemic in other countries (Feiring & Westdahl, 2020). Considering the rapid increase in demand for and use of remote interpreting services brought about by the COVID-19 pandemic, coupled with the potential for continued high demand for remote interpreting services after the pandemic, the NCIHC Research Work Group sought to understand the challenges faced by interpreters who provide remote interpreting services in healthcare settings.

Method

The survey questionnaire had 64 answerable items with multiple-choice and open-ended responses. The NCIHC Research Work Group distributed the questionnaire online with the support of the NCIHC Board, several interpreting organizations, and numerous language service companies. The survey was open from February 14 to April 23 of 2021. A total of 1,673 working healthcare interpreters responded; of these 1,114 self-identified as female, 199 as male, 4 as nonbinary, 3 as other, and 25 indicated they preferred not to answer, while 328 did not respond to this question. The interpreters were from 38 states, communicating in 87 different languages.

For this article, the responses to Questions 18–20 and 40–47, which relate to interpreting modalities, are presented. The results of both quantitative and qualitative responses were

considered. The quantitative data were subjected to Fisher's one-tailed test with 1 degree of freedom, 99% degree of confidence, and 0.01 degree of error. The open-ended questions were examined and tabulated based on identified categories.

Results

Out of 1554 respondents who answered Question 19 (see table below), only 9% (*n* = 84) reported an increase in on-site interpreting. The majority (61%, *n* = 949) indicated that the modality in which they interpret changed as a result of COVID-19. When indicating how the modality had changed, in Question 20 (see table below), several respondents indicated that the change is an increase in providing interpreting services over video remote (46%, *n* = 437) and telephone interpreting (49%, *n* = 466), where the patient and provider are at the same location. This change represented a total of 95% (*n* = 903) of participants switching to remote interpreting. Additionally, many respondents indicated an increase in the use of telemedicine or telehealth solutions, where the patient and provider are located in different settings—50% of respondents (*n* = 474) noted an increase in interpreting over a video telemedicine solution, and 47% of respondents (*n* = 443) noted an increase in interpreting over a telephone telemedicine solution.

Q19: Has the modality in which you interpret changed as a result of COVID-19?

Q19	**Count**	**%**
No	605	39%
Yes	949	61%

Q20: How has the modality changed? Mark all that apply.

Q20	**Count**	**%**
More on-site (face-to-face)	84	9%
More remote telephone (patient and provider in the same setting)	466	49%
More remote video (patient and provider in the same setting)	437	46%
More telemedicine/telehealth via telephone (patient and provider in different settings)	443	47%
More telemedicine/telehealth via video (patient and provider in different settings)	474	50%

Q40: Since the onset of COVID-19, have you provided remote interpreting services in health care?

Q40	Count	%
No	328	22%
Yes	1131	78%

Responses to Question 41 are available below. A full analysis of responses to Question 41(*n* = 1,131) is available in [Issue 1 of Access: The NCIHC Journal.]

Q41: In working with providers and patients using remote interpreting, what challenges have you frequently encountered? Mark all that apply.

Q41	Count	%
Provider or staff speaks in a manner which is difficult for me to understand (for example: speaks with a strong accent, mumbles, does not articulate clearly, speaks too fast, etc.).	606	54%
Managing linguistic/vocabulary challenges related to technical terms or specific medical information (like treatment instructions, medication guidance, diagnostic explanations, patient education, etc.).	209	18%
The conversation is highly emotional (for example: anxiety expressed by the patient or a family member, expression of sympathy to the patient, adverse reactions by the patient to explanations given by the provider, etc.).	305	27%
The conversation involves written documents requiring me to see the paperwork or do sight translation.	266	24%
The conversation involves visual cues (like gestures, facial expressions, full view of the room).	414	37%
The conversation involves body movement (like 'Move your foot like this,' 'Can you bend this way?', 'You'll want to insert that tab here').	501	44%
Use of masks and/or ventilators hinder communication.	641	57%
Other (please specify)	299	26%

Q41 Cont. Other (Please specify) responses	Count
Technical Issues	138
Audio/Visual Quality	89
Inadequate knowledge of Provider, Staff, & Patient	125
Environment	28
Others	35
No Challenges	22
Incomplete/invalid entries	10

Of those 1,131 respondents that indicated that they have provided remote interpreting services in health care since the onset of the pandemic, 31% (*n* = 350) indicated that they did not believe any interactions have been impacted by remote interpreting as a result of COVID-19. However, 50% (*n* = 561) of said respondents indicated that rapport between the provider and the patient has been impacted by remote interpreting as a result of COVID-19. Additionally, 42% (*n* = 479) indicated that rapport between the provider and the patient has been impacted, and 39% (*n* = 439) indicated that rapport between the interpreter and the provider has been impacted.

Q42: In your opinion, which of the following interactions have been impacted by remote interpreting as a result of COVID-19? Mark all that apply.

Q42	Count	%
Rapport between the provider and the patient	561	50%
Rapport between the interpreter and the patient	479	42%
Rapport between the interpreter and the provider	439	39%
I do not believe any interactions have been impacted.	350	31%

When the 1,131 respondents that indicated that they have provided remote interpreting services in health care since the onset of the pandemic were asked to compare telephone interpreting to on-site interpreting, more respondents seem to favor on-site interpreting; 47% (*n* = 528) indicated that telephone/video interpreting is more tiring and 16% (*n* = 184) indicated it is less tiring, 46% (*n* = 517) indicated that telephone/video interpreting is less accurate and 4% (*n* = 49) indicated it is more accurate, and 21% (*n* = 240) indicated that telephone/video interpreting is less confidential and 11% (*n* = 124) indicated that it is more confidential. It is important to note that 8% (*n* = 85) indicated that they have not worked on-site, and 18% (*n* = 198) of respondents selected “Other” and provided a written response. In their written answers, 65 respondents expressed that telephone/video interpreting required more effort and was less convenient than on-site interpreting, often citing technical and audio/visual issues along with the lack of personal interactions and poor working conditions. On the other hand, 39 respondents described telephone/video interpreting as requiring less effort and being more convenient because it saves interpreters from long and stressful commutes and allows interpreters to use time more efficiently and interpret for more patients. Furthermore, through written responses, 46 respondents indicated that telephone/video interpreting is less effective than on-site interpreting, compared to only 7 who indicated the contrary. In written responses, 15 respondents indicated that telephone/video interpreting and on-site interpreting are equivalent, and 15 respondents provided other responses that did not fit any of the other categories, with some noting that each modality is appropriate for different situations, others highlighting that remote modalities (like telephone or video) are an adequate alternative to providing no language or communication access, and several noting a preference for video over the telephone if a remote modality must be utilized. Finally, there were 30 written responses that were incomplete, did not address the question at hand, or simply elaborated on their selection.

Q43: Comparing telephone/video interpreting with on-site interpreting, which statements best describe your experience? Mark all that apply.

Q43	Count	%
I have not worked on-site	85	8%
Telephone/video interpreting is more tiring than on-site interpreting.	528	47%
Telephone/video interpreting is less tiring than on-site interpreting.	184	16%
Telephone/video interpreting is more accurate than on-site interpreting.	49	4%
Telephone/video interpreting is less accurate than on-site interpreting.	517	46%
Telephone/video interpreting is more confidential than on-site interpreting.	124	11%
Telephone/video interpreting is less confidential than on-site interpreting.	240	21%

Other (please specify)	198	18%

Q43 Cont. Other (Please specify) responses	Count
Telephone/video interpreting requires more effort and is less convenient than on-site interpreting.	65
Telephone/video interpreting requires less effort and is more convenient than on-site interpreting.	39
Telephone/video interpreting is more effective than on-site interpreting.	7
Telephone/video interpreting is less effective than on-site interpreting.	46
Telephone/video interpreting is equivalent to on-site interpreting.	15
Other	15
Incomplete/invalid entries	30

When evaluating their level of personal readiness for remote interpreting, 67% (*n* = 754) of respondents indicated that they have learned to adapt and adjust to remote interpreting as they take assignments, 60% (*n* = 679) of respondents indicated that they have a designated workplace at home to conduct remote interpreting, and 45% (*n* = 513) of respondents indicated that they have invested time and money to be ready for remote interpreting. Only 4% (*n* = 48) of respondents indicated that they were hesitant to accept assignments because they did not have the skill or technology to do it. In written responses to "Other (please specify)," 21 respondents indicated that they started working in remote modalities before the pandemic, and 25 reported that either their employer provided the equipment or provided both the equipment and location for remote interpreting. Additional written responses were categorized as "Other" if they either elaborated on the respondents' selections or were incomplete responses.

Q44: In terms of personal readiness for remote interpreting, which of the following apply to you since the onset of COVID? Mark all that apply.

Q44	Count	%
I have invested time and money to be ready for remote interpreting.	513	45%
I have a designated workplace at home to conduct remote interpreting.	679	60%
I learned to adapt and adjust to remote interpreting as I take assignments.	754	67%
I am hesitant to accept remote interpreting assignments because I don't have the skill or technology to do it.	48	4%
Other (please specify)	112	10%

Q44 Cont. Other (Please specify) responses	Count
Worked in remote modalities before the pandemic and/or already had the needed equipment	21
Employer provides remote interpreting location and/or equipment	25

Other	63

Of 1,581 respondents that answered Question 45, 62% (*n* = 656) indicated that they have experienced problems with the reliability of the equipment or internet connection, with the most common problems experienced reported (in Question 46) as internet connection problems (83%, *n* = 547) and problems with background noise at the patient end (74%, *n* = 487).

Q45: Have you experienced problems with the reliability of the equipment or the internet connection you use to conduct telephone/ video interpreting during the pandemic?

Q45	Count	%
No	406	38%
Yes	656	62%

Q46: Please specify what problems you have experienced. Mark all that apply.

Q46	**Count**	**%**
Problems with internet connection (such as slow to activate, gets pixelated, slows down, freezes mid-session or drops without notice)	547	35%
When using platforms such as Zoom, Google Team, etc. I have had difficulty accessing the platform or connecting with others in the session	246	16%
The Voice Over Internet Program that I use has poor audio quality	102	6%
Problems with headsets	142	9%
Problems with background noise at my end	160	10%
Problems with background noise at the patient end	487	31%
Other (please specify)	100	6%

Q46 Cont. Other (Please specify) responses	**Count**
Inadequate technology	26
Inadequate knowledge of Provider, Staff, & Patient	13
Problems with background noise at the provider end	25
Technical Issues	11
Other	17
No Issues	3
Incomplete/invalid entries	4

When asked about common issues encountered during remote interpreting as a result of COVID-19, 25% (*n* = 285) of respondents indicated that they did not experience any issues, with an additional 5 respondents indicating the same in written form; 44% (*n* = 493) of respondents indicated that lack of briefing about issues related to the medical situation is a common problem, and 24% (*n* = 271) selected pressure from the provider to end conversation within a certain time as another common problem. A total of 70 responses were related to technical issues and/or environment (ambiance), which include any written responses that indicated any issues like poor connection or inadequate equipment, platform, and/or environment. In written form, under the "Other" category there are responses related to lower pay provided for remote interpreting services and a variety of other issues that did not fit any of the other categories, including one comment that suggested that providers may opt to "get away with no interpreter" or resort to family/friends because of issues encountered with remote modalities. Additionally, some respondents suggested that said issues may be producing greater health disparities for vulnerable patient populations who either lack knowledge of how to interact with the technology; are provided instructions only in English; receive information through methods of communication that are not monitored by patients, such as email; and/or lack adequate resources to secure the ideal technology. These statements merit further investigation. Finally, a couple of written responses indicated that none of the issues respondents encountered are unique to COVID-19 but rather are a result of the use of remote modalities.

Q47: What issues (if any) do you commonly encounter during remote interpreting as a result of COVID-19? Mark all that apply.

Q47	**Count**	**%**
I do not experience any issues.	285	25%
Lack of briefing about issues related to the medical situation	493	44%
Lack of briefing about issues with the equipment	173	15%
Equipment set-up takes up a large amount of time.	148	13%
Pressure from the provider to end conversation within a certain time	271	24%
The whole assignment takes much longer than I expected.	194	17%
Other (please specify)	166	15%

Q47 Cont. Other (Please specify) responses	**Count**
Technical issues and/or environment	70
Inadequate knowledge of Provider, Staff, & Patient	18
Flow of communication	20
Delays that prevent appointments from starting as scheduled	14
Other	41
No issues	5
Incomplete/invalid entries	4

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