



**NCIHC**

**NCIHC Open Call**

**May 25, 2007**

**12:00 – 1:30 PDT**

**Topic:**

**On-site and Remote Interpreting: When is Each Appropriate**

The NCIHC Open Calls are held quarterly, as a means of encouraging exchange among professionals working in the field of language access and soliciting input from practitioners in the field to inform NCIHC policy making.

**Participants:** about 32 total (from freeconference.com report)

**Introduction**

The open call began with a short introduction. Cornelia E. Brown, from the NCIHC Outreach Committee, explained the background of the NCIHC open calls. She reviewed the mechanics of the call and then introduced this month's topic: on-site and remote interpreting: when each is appropriate. She then introduced our guest specialists: Nataly Kelly (Independent consultant), Dr. Francis Chabot (affiliation?), Gloria Garcia-Orme and Bruce Occena (San Francisco General Hospital).

Nataly Kelly spoke about the benefits of telephonic interpreting:

- **Ease of access**  
Telephonic interpreting is available 24/7 in a wide variety of languages. This is especially helpful for finding interpreters in languages of limited diffusion, during off-hours, in times of immediate need, and when it is important to have access to an interpreter who is not part of the patient's social group. Some hospitals are beginning to use their own staff interpreters to do telephonic interpreting, allowing for more efficient use of staff time.
- **Appropriateness for certain types of interactions**  
Telephonic interpreting is the most appropriate modality to provide language services for calls that will be over the phone anyway, such as: tele-health, tele-medicine, telephonic care management, crisis counseling hotlines, emergency services such as 911, nurse advice lines, and administrative services over the phone. It is also more appropriate for

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settings in which it is better not to have an additional person in the room, for example certain sexual and reproductive health settings.

- **Quality**

There is little research on the impact of interpreting service modality on the quality of communication. A study by Angelelli of the same interpreters doing first in-person and then telephonic interpreting found no difference in the quality of the interpreting with respect to accuracy and completeness. Several studies have found conflicting patient satisfaction data. Some telephonic interpreting providers do have longstanding quality assurance programs in place.

Nataly then spoke of the challenges of telephonic interpreting.

- **Ease of access**

Telephonic services may be too easy to access, leading to a reluctance to get an on-site interpreter even when it would be preferable for patient care. Also, ease of access depends on the provider in question. Some organizations report excessive wait times, especially for less commonly requested languages. Consumers need to make informed choices about providers using criteria related to ease of access when procuring vendors.

- **Appropriateness**

Telephonic interpreting is not appropriate when visual elements are necessary, when the patient is hard of hearing, when the patient is a young child, when more than two parties are involved in the interaction, and during mental health appointments.

- **Quality**

Not all telephonic providers are providing high quality interpreters. In addition, depending on what they are comparing it to, patients and providers are not always as satisfied with telephonic.

Nataly's summary: telephonic interpreting is not always the best choice for every setting, but a trained telephonic interpreter is always better than an untrained on-site interpreter.

Dr. Francis Chabot then spoke on the benefits and challenges of on-site interpreting, as he has experienced it through his experience at a medical center in Utica, NY.

- Clear communication is critical to the diagnostic process.
- Cost is a key factor in providing this service; interpreters need to be paid, and they need to be trained. But cost of paying for interpreters is a real barrier, so private practitioners in particular are looking for cheapest option. Telephonic may be used even when not appropriate.
- Providers prefer on-site – handing handset around and the loss of body language impede the development of the patient-provider relationship and the medical interview.
- Trained interpreters, telephonic or on-site, are always better than untrained interpreters, whether telephonic or on-site.
- Video may be the way to go in the future, from laptops wherever the interpreter is.

Gloria GarciaOrme and Bruce Occena then spoke about their video-interpreting program at San Francisco General Hospital (SFGH). SFGH is a large metropolitan public hospital, with an extensive community-based clinic system attached. It uses both staff interpreters (12-14 languages) and as needed (SFGH employees) interpreters (35 languages).

A few years ago, SFGH received a grant to pilot a video medical interpreting (VMI) system, to link the interpreters between SFGH and Alameda County Medical Center. The program was first implemented in outpatient departments, as these were the departments that were being made to wait the longest as the out patient clinics have the highest volume and trauma cases were given priority. Speaker phones were also installed in clinic room, and they continue to have access to in-person interpreters when necessary.

Bruce Occena spoke on how decisions are made about which modality of interpreter service to use. In-person interpreting, video interpreting and telephonic interpreting are all offered to providers and are all provided by staff interpreters. Providers were not prepared to give up visuals, so the providers supported the shift to video, but not to telephonic. So, if no choice is indicated, the default is video.

However, with all three choices offered, providers started to triage differently. In short visits with long-time patients, providers are using more telephone. They use video more with new patients, for long medical histories, where body language will be crucial. Providers choose in-person interpreters for interactions with nuanced communication, e.g., with patients who are hard of hearing, for difficult diagnosis, for giving bad news, and with psychiatric issues.

Interpreters can handle all three with ease. Interpreters are given the authority to change modality if the communication is breaking down. Telephonic is hardest if the interaction is long – video or in-person seem easiest for long appointments.

As a result of all this, telephonic interpreting use has gone up, video has gone up, and in-person gone down. Total number of patients served has increased. Gloria feels that the system is more efficient and is providing more comprehensive service. Before, doing only in-person interpreting, interpreters could do 1.5 service units an hour. Now, with the variety of modes available, interpreters are doing 5-6 service units per hour. There have been virtually no dropped calls.

## **Discussion**

Participants on the call then discussed the following questions.

1. We know that remote interpreting solves many of the logistical difficulties of language access programs. Is anything lost, however, when a remote interpreter is used? If so, what?
  - Having a bilingual provider is best; next is in-person interpreters. But hospitals just can't meet the demand with in-person interpreters. Still, when we go remote, we lose the interpreter's contribution to advocacy, way-finding, and patient support. At SFGH, the patients have not complained as they went to remote interpreting, as they

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were so happy to have an interpreter quickly.

- We lose consistency if the remote interpreting is being offered through large off-site companies. If we use staff interpreters through video connections, at least the patients know the interpreters. And providers know they can address quality issues with staff interpreters. They don't handle quality issues the same with external vendors; they just hang up and try again, hoping to get a better interpreter.
- Patients are often reluctant to ask for clarification. In-person interpreters can see the body language that says that patient didn't understand, but telephonic interpreters cannot. Remote video seems to solve this problem. Patients seem to be comfortable with video after the first or second time.
- What kind of money is saved with video? Money COULD be saved, but SFGH is more interested in being more efficient so that they can expand services to all patients.
- Do you think we'll be moving toward video large scale? Yes, as more hospitals go digital and wire for other purposes.

2. When do you think that use of an **in-person** interpreter results in better care for the patient? Why?

- Mental health interactions, but video may be OK too.
- Bad news
- When advocacy is needed.
- When relationship needs to be built, e.g. when the patient is new.
- When nuance is central to the communication.
- All of this is true only when trained in-person interpreters are available immediately. When providers have to wait for in-person interpreters, or in-person interpreters aren't trained, remote may be better for the quality of the interaction.
- One hospital in OH uses only video interpreting for its ASL patients, and the deaf community doesn't like it. They feel that video-interpreting is 2-dimensional, not 3-dimensional. Providers need to be trained not to block the screen when they are talking, and to place the screen so that patient can see regardless of patient position.

- Some hospitals in NYC are going to video interpreting without consulting with deaf community. This is a concern, due to connectivity issues, regional differences in sign language, and a resulting lack of trust.

3. When do you think that use of a **remote interpreter** is the better choice? Why?

- Could use remote for short and for administrative interactions.
- Ideal to leave it to the provider to choose – they will triage based on best care for their patients. So it's a good option when remote interpreters can be accessed quickly, efficiently and when other options are available when the provider deems it necessary.
- Always better when the other option is an untrained interpreter.
- Best when remote interpreters are local and could also provide in-person interpretation, so patients become accustomed to interpreters and interpreters know the facility and local needs. Finding training might be hard.
- When in-person interpreters have a high no-show rate.
- When patients have a high no-show rate.

4. We would hope that quality of care would be the primary motivation for choosing a modality for providing interpreting, but we know there are many other concerns that determine when each is used. What are those concerns, and how can they be addressed?

- Cost
- Ease of access: how do we make sure providers choose on the basis of quality of care instead of what's easiest? Constant re-education of the providers is needed. It is important to have doctor-champions who push this issue.
- Availability of trained interpreters
- Nobody seems to ask the patients what they prefer. SFGH did and video got rave reviews.
- Colonial inequalities can carry over into US medical interpreting settings, where the more acculturated speakers may reach positions of influence with large interpreting companies, refugee and other organizations and ignore the language needs of formerly oppressed groups from their native land. Speakers of minority languages

report being told that they speak the “same” language as the majority, while, in fact, they cannot understand interpreters speaking the majority language. An example would be assuming that a speaker of Maay Maay (Somali Bantu) can understand a speaker of Somali (ethnic Somali).

5. Do you think the NCIHC should produce a White Paper on this topic, or is the guidance already available in the field sufficient?
  - Yes, as a summary of the current thinking in the field.
  - Should include the things we’ve talked about today.

### **Summary and conclusion**

At 1:25 PDT, Cindy Roat, who had been taking notes on the discussion, summarized the ideas that had been shared on the call.

The call was concluded at 1:30 PDT, with a request to participants to send more ideas for Open Calls to Cindy Roat at [cindy.roat@alumni.williams.edu](mailto:cindy.roat@alumni.williams.edu).