4-28-2021

In-Person vs Telephonic Interpretation: A Case Study from the Perspective of Providers and Interpreters at a Virginia Free Clinic

Lucy Cummins
University of Richmond

Recommended Citation

Cummins, Lucy, "In-Person vs Telephonic Interpretation: A Case Study from the Perspective of Providers and Interpreters at a Virginia Free Clinic" (2021). *Honors Theses*. 1584.
https://scholarship.richmond.edu/honors-theses/1584

In-Person vs Telephonic Interpretation:

A Case Study from the Perspective of Providers and Interpreters at a Virginia Free Clinic

by

Lucy Cummins

Honors Thesis

Submitted to:

Department of Anthropology
University of Richmond
Richmond, VA

April 28, 2021

Advisor: Dr. Jan French

Table of Contents

Acknowledgements

There have been so many individuals who have supported the research and writing presented in this thesis. First, I would like to thank everyone I've worked with at Health Brigade for welcoming me into your incredible organization, and for trusting me to contribute to your mission and the care of your patients. Thank you to Dr. Rachel Waller for being supportive of my research from the beginning, and for becoming a professional mentor and role model to me over the past year. To Dr. Wendy Klein and Anne Gibbons, thank you for bringing me into Health Brigade as a volunteer back in the beginning of 2020, and for guiding and encouraging my work ever since. Jasmine Fisher, Kelsea Jeter, and Nidian Kincaid, thank you for continuing to invite me into your meetings every week as we've built up the interpretation program. Thank you as well to the many other staff members and volunteers I've worked with at Health Brigade along the way- your tireless dedication to promoting equity in healthcare inspires me.

Dr. Indira Sultanic and Patricia Gavilan, I so appreciate your additional insights based on decades of experience with medical interpretation. Thank you for taking the time to share your expertise and contribute to this project.

The University of Richmond's Center for Civic Engagement helped me to locate some of my first positions as an interpreter, and later provided funding for me to spend a summer working with Health Brigade through a David Burhans Civic Fellowship. I am so appreciative of all of the opportunities I've had through the CCE over the past four years, but especially of those that culminated in this research, which would not have been possible without CCE support. Thank you to all of the dedicated and encouraging CCE staff, especially Dr. Derek Miller who coordinated my fellowship funding.

I am deeply grateful to the professors who've led me to fall in love with anthropology over the last four years- Dr. Derek Miller, Dr. Jan French, Dr. Margaret Dorsey, Dr. Jennifer Nourse, Dr. Rania Sweis, and Dr. Miguel Diaz-Barriga. I am especially grateful to Dr. French. You have been a mentor to me ever since I first entered your classroom in 2018, and have supported me through the academic, professional, and personal ups and downs of my undergraduate career. Your advice in each of these areas has been invaluable in leading me down the path I am on today, and in giving me the confidence to pursue my goals in college and afterwards. With this project in particular, thank you for countless weekly meetings, draft reviews, and discussions of everything from research ethics to the nuances of patient-provider communication. I can very surely say that I would not have completed this thesis without your guidance, and I am so thankful for the time and energy you've poured into supporting my research.

Finally, thank you to the individuals who have made up my personal support system over the past four years. Mom, Dad, Carson, Jack, Angela, and many other friends and family members along the way, none of this would have been possible without your endless encouragement and reassurance at the times I needed it most.

-Lucy Cummins, April 2021

Introduction

In the past year, the coronavirus pandemic has triggered a revolution in the ways we communicate with one another. Friends, colleagues, neighbors, and family members are finding their interactions pushed onto their phones and computers. So too are doctors and patients, as the slow adoption of telehealth by some providers was catalyzed dramatically by office closures and social distancing requirements. This was certainly the case at Health Brigade, a community free clinic in Richmond, Virginia. In March of 2020, providers and staff at the clinic, in a Herculean logistical feat, transitioned almost all of its patient appointments from in-person visits to phone calls. For many patients, this meant adapting to the entirely new experience of speaking to their provider through a technological intermediary. For more than half of Health Brigade's patient population, though, using a phone to discuss their health was nothing new. At Health Brigade, as at so many clinics and hospitals around the United States, patients with limited English proficiency (LEP) work with interpreters- often contacted via telephone- who facilitate effective communication with their care providers.

In hospitals and clinics across the US today, telephonic and in-person interpretation are both common. Especially at larger hospitals, in-person interpreters may be available to accompany LEP patients through their care. Telephone interpretation, though, is nearly ubiquitous in medical settings that provide interpretation services for their patients. Indeed, phone interpreters can be an efficient and potentially cost-effective alternative to hiring in-person interpreters. Thus, LEP patients will likely work with both telephonic and in-person interpreters during their lifetime medical care. The diversity of communication experiences LEP patients may be offered in discussions with their providers begs the question of whether one mode of interpretation offers any benefits or drawbacks relative to others. With the work that follows, I investigate this question through a case study of Health Brigade- a clinic with extensive experience working with LEP patients and communicating through both in-person and telephonic interpreters. I seek to understand how the mode of interpretation in a free clinic setting impacts the care that patients receive and the relationship they have with their provider, and to recount the personal experiences of providers and interpreters with in-person and telephonic interpretation. Ultimately, in my year of my ethnographic research at Health Brigade I've found that in-person interpretation, from the perspective of providers and interpreters at a community free clinic, provides more positive and productive clinical encounters for LEP patients. As one interpreter I interviewed put it, "If I were to choose…I would definitely choose to [interpret] in-person. I think that everyone gets the most out of it and I feel like the communication is easier and more accurate." Easy, accurate, communication that all parties can draw from is the ideal outcome of medical interpretation for LEP patients and their providers. I hope that this investigation and this finding aids in illuminating the ways that medical providers and interpreters can better serve all of those they care for, regardless of the language that they speak.

Study Setting: Virginia Free Clinic

In the United States, more than 50 percent of the population will fall below the federal poverty line at some point before they are 65 (Moores, 2021). Due to the incredible expense of health insurance in the US, many of these individuals find themselves unable to afford medical care. Free clinics exist as a safety net for the uninsured and underinsured, and provide an avenue for those who face structural barriers to healthcare to receive the services they need. Many free clinics offer a range of resources beyond primary care, from case management, to legal or financial assistance, to mental health care in order to “treat the whole patient by providing a combination of care that addresses not only healthcare needs but also social needs” (VAFCC, 2021). This philosophy makes free clinics unique, as they move beyond diagnosis and treatment of illness to address some of its root causes, and to care for patients and their loved ones as whole people, not simply collections of symptoms.

In a 2010 survey of 1,007 free clinics, clinics reported that an average of 39% of their patient population was comprised of immigrants to the US (Darnell, 2010, 949). The large majority of this group was reported to have limited English proficiency. Given the high proportion of LEP individuals that free clinics serve, many have significant experience working with speakers of languages other than English and their interpreters. The breadth of medical care and other services that free clinics provide means that providers and staff often know their patients well and have close relationships with them and their loved ones. This combination of experience with and investment in encounters with LEP patients makes a Virginia free clinic an ideal setting for a case study of the effects of in-person and telephonic interpretation on provider-patient relationships and care quality. As a well-established free clinic where more than half of all patients have limited English proficiency, and where providers often develop strong relationships with their patients over many years, Health Brigade will serve as a model for this investigation of interpreting mode.

Methodology and Ethical Considerations

A Note on Engaged Anthropology

In my undergraduate study of anthropology over the last four years, I have been captivated by the work of anthropologists who not only study and write about the communities where they work, but engage more intimately with the issues they encounter there. Reading Nancy Scheper-Hughes, Paul Farmer, Charles Briggs, and Sarah Horton, I've learned about the incredible advocacy and on-the-ground work they are each doing to promote justice and equity in the communities they study. This kind of engaged anthropology is why I fell in love with the discipline, as I've come to believe that its traditions of ethnographic fieldwork and participant observation hold vast potential to inform positive social change. As Setha Low and Sally Engle Merry write in their report on the growth of engaged anthropology, anthropologists can and should use their unique knowledge and training to serve dual roles in "sharing and support, teaching and public education, social critique, collaboration, advocacy, and activism" (2010, 203). I am excited by this possibility, and by the potential for symbiosis between social justice work and ethnographic study, with each informing the other.

With this project, I attempt my own foray into engaged anthropology. I have volunteered as a medical interpreter for Spanish-speaking patients for several years at three different free clinics, and now am one of the coordinators of Health Brigade's volunteer medical interpretation program. I have seen for myself a rapid transition to telephonic interpretation from in-person after the onset of the COVID-19 pandemic, and want to use my anthropological training to better understand its impact. I believe that my own experience as an interpreter facilitates my investigation of this question, and that ethnographic study will allow me to contribute more to the work I do now in interpretation program development. The two roles, in a sense, are mutually productive and beneficial to my understanding of medical interpretation. Further, I hope that my work from both of these angles- as an anthropologist and an interpreter- in some way promotes positive change in the medical care provided to LEP patients.

Interviews

I conducted formal, semi-structured interviews with two longtime Health Brigade providers, and three experienced volunteer interpreters who have worked in-person and over-the-phone with the clinic. These interviews were approximately one hour in duration, took place via video call, and were recorded for later transcription and analysis. I recruited interview participants via email from the pool of current staff and volunteer providers, and active volunteer interpreters at Health Brigade. I employed two different guides as a starting point for my interviews with participants, one for providers and one for interpreters. The interview guide for providers focused on their background with Health Brigade, experience working with LEP patients, and opinions about in-person and telephonic interpretation. The interpreter guide asked similar questions about background with Health Brigade and with interpretation, as well as experiences working in-person and over the phone as an interpreter. As my conversations with each study participant evolved, I included additional questions in all of their interviews to more deeply understand their opinions and experiences.

A notable group excluded from interviews for this study is Health Brigade patients who use interpreters. Upon my initial proposal of a study involving interviews with patients to my advisors at the University of Richmond and at Health Brigade, ethical concerns were raised about whether patients might feel obligated to participate in the study “in exchange” for the free medical care they received. Further, questions about maintaining full confidentiality of sensitive patient information, especially given the vulnerability of many Health Brigade patients, led to my decision to narrow the study’s scope to provider and interpreter opinions. Providers and interpreters at Health Brigade do have extensive experience working with LEP patients, though, and provide both valuable and unique insight on the impact of interpreting mode on clinic workflow and patient care.

Ethics

This project was approved by Health Brigade's Medical Director and by the University of Richmond Institutional Review Board. All interview participants were over the age of 18, gave informed consent, and their participation in the study was entirely voluntary. Interviewee data has been deidentified, and interview recordings were stored securely and erased after analysis. Any potentially identifying information regarding Health Brigade patients was excluded from this report.

Health Brigade

History of the Clinic

Health Brigade opened in the Fan District of Richmond, Virginia in 1970 (Health Brigade, 2021). It was called Fan Free Clinic at the time, and was the first free clinic established in the Commonwealth of Virginia. It was born of the countercultural movements of the 60s and 70s, and its initial purpose was to serve the students of Virginia Commonwealth University ("Health Brigade…turns 50," 2020). In particular, it provided access to birth control for students, a courageous move of questionable legality as unmarried women's rights to use contraception were not firmly established in the US until the Supreme Court case *Eisenstadt v. Baird* in 1972 (Oyez, n.d.). Fan Free Clinic staff and volunteers were also known to wear "arm bands identifying us as medical personnel" as they joined local protests to provide first aid (Health Brigade, 2021). However, clinic staff and volunteers quickly found that their services were attracting a far wider patient population than they had anticipated. Word spread about a new clinic providing medical care free of charge, and Fan Free Clinic was quickly overwhelmed by Richmonders without access to healthcare seeking their services. As a December article in the Richmond News Leader put it in a headline that year, “Clinic’s Big Problem is ‘Wall-to-Wall People’” (“Health Brigade…turns 50,” 2020).

Fan Free Clinic continued to grow into the 1980s, when it would take on a primary role in caring for AIDS patients. As many suffering from HIV and AIDS were abandoned by friends and family who fell victim to the fearmongering of the time, Fan Free Clinic created “care teams whose members would cook, clean, house, and care for people who could no longer provide for themselves” (Giddens, 2019). By the 1990s, Fan Free Clinic was “known as ‘the’ place where you could obtain services and support if you were infected or affected by HIV/AIDS” (Health Brigade, 2021). During the 80s and 90s, the clinic began to grow to formally encompass mental health, case management, and health outreach services on top of the primary medical care it was founded on.

In the early 2000s, Fan Free Clinic became the first, and still only, free clinic in Virginia to offer transgender health services, including hormone treatment, surgery support letters, and legal services for name and gender changes (Health Brigade, 2021). Fan Free Clinic’s Trans Health division quickly grew to serve more than 200 individuals. The clinic’s outreach to and care for

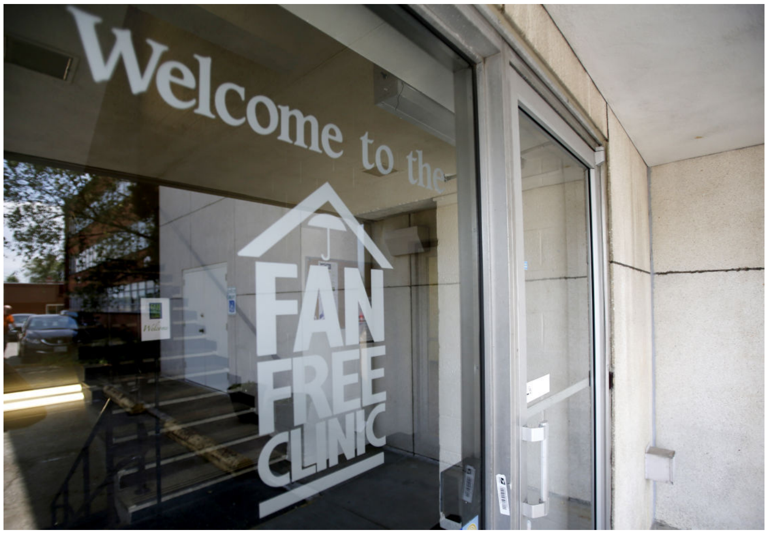

Figure 1. The Fan Free Clinic before its 2016 name change (Demeria, 2016).

marginalized communities has clearly been a core tenet of its identity throughout its 51-year history. Indeed, it continues to be a pioneer among Richmond and Virginia nonprofits. It has begun offering healthcare services to incarcerated individuals, as well as counseling and case management for those who have recently been released. In 2018, it founded the first needle exchange and comprehensive harm reduction program in central Virginia in response to the opioid epidemic. In 2016, Fan Free Clinic changed its name to Health Brigade, in part to honor the clinic's 51-year legacy of confronting the "tough health issues of the day when others retreated." The organization prides itself on seeking out and running to face injustice, much like a bucket brigade to a fire.

The Clinic Today

Still located in the Fan District, Health Brigade now houses a full primary care clinic and staff offices on its first floor, a mental health clinic on the second, and additional storage and event space for community outreach in the basement. It serves nearly 12,000 patients annually between its Primary Care, Mental Health and Wellness, and Health Outreach divisions (Edwardson, 2020). In recent years, one of the most dramatic changes that Health Brigade has seen in its patient population is an increased proportion of individuals whose primary language is not English. Indeed, more than 50 percent of the clinic's current patients are Spanish speakers, and most utilize its medical interpretation services.

Figure 2. The current Health Brigade building (Copeland, 2018).

Interpreters at Health Brigade are volunteers, all of whom speak both English and Spanish. The clinic evaluates new interpreter candidates for Spanish proficiency and interpreting ability, and then provides training on best practices in interpretation and Spanish medical terminology. Those candidates who successfully complete evaluation and training shadow an experienced interpreter for two four-hour shifts, then take on two more shifts where they interpret under the supervision of an experienced interpreter. These four shifts, along with evaluations from their supervising interpreter and any providers they worked with, complete the training process. Fully trained interpreter volunteers work at least one four-hour shift every week during which they interpret for any Spanish-speaking patients who come to the clinic. Typically, this work takes place in-person at the Health Brigade office, but in the last year it has gone remote due to the clinic's COVID-19 precautions, and interpreters work with patients and providers over the phone. Through its volunteer interpreters, Health Brigade is able to fulfill its mission of providing "exceptional health services to those least served," and to ensure that patients with limited English proficiency receive the same high-quality care as English speakers at the clinic.

My Involvement with the Clinic

I first became aware of Health Brigade's work as a sophomore pre-medical student searching for opportunities to better understand the landscape of nonprofit healthcare work in Richmond. Though an internship in Boston and a semester abroad in Denmark took me away from the city for close to a year, I stayed in touch with Health Brigade's volunteer coordinator. Upon my return to Richmond in January of 2020, I began volunteering as a medical interpreter at the clinic. For several months, I spent at least one afternoon a week liaising between providers and their Spanish-speaking patients during medical appointments. I was able to witness the emphasis that Health Brigade providers place on knowing their patients as whole people in order to address all of their health needs, and the care that they take in meeting patients wherever they are.

When it became clear in March that COVID-19 was much more than a few cases of a novel virus in another part of the world, my work with Health Brigade transitioned to a telehealth model. I interpreted for LEP patients over the phone from thousands of miles away, passing the time in my childhood home "on call" for several afternoons every week. I came to know well the challenges with cell signal and background noise that can plague telehealth appointments, but also the success that Health Brigade found in maintaining continuity of care throughout the pandemic. That spring I received a grant from the University of Richmond's Center for Civic Engagement to further my work with Health Brigade, and made plans to travel back across the country. When in May I was able to return to Richmond, I helped to coordinate Health Brigade's COVID testing program, as the clinic characteristically sprang into action to provide testing services for Richmonders who needed them. I worked especially closely with our team of bilingual registrar volunteers to make testing accessible to Spanish-speakers, and with several organizations serving Richmond's Latinx community to promote Health Brigade's free testing services.

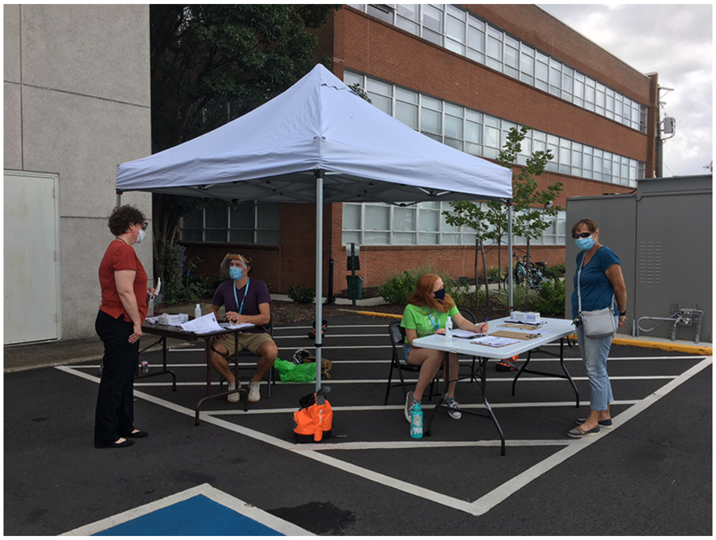

Figure 3. Registering "patients" (staff members staged for privacy purposes) for COVID-19 testing. I am sitting at the table in green.

As the summer came to an end, I returned to my prior volunteer focus and joined a dedicated team of Health Brigade staff working to rebuild and revamp the clinic's medical interpretation program through improved recruitment, training, and evaluation. When the team first met in August, our volunteer interpreter roster was slim, and certainly nowhere near large enough to meet the needs of the clinic's Spanish-speaking patient population. Providers had to rely heavily on outside interpretation services, which are expensive for the clinic and can be cumbersome to navigate. Throughout the fall, I worked with the team to recruit a new crop of volunteer interpreters who could fully staff our telehealth schedule. I developed and ran an interpreter training workshop in conjunction with the head of Virginia Commonwealth University's Spanish-English Translation and Interpretation program to introduce volunteers to ethics and best practices in interpretation, as well as what their roles would look like at Health Brigade. I compiled a set of reference sheets with Spanish medical terminology relevant to the clinic's work, and a guide on using Health Brigade's telehealth technology.

Today, much of my work with the interpretation team centers around the evaluation of new interpreter candidates and monitoring of current volunteers. Since our initial wave of recruitment in August we have continued to receive applications, and have designed a process to select and train volunteers who will best serve Health Brigade's patients. I am in charge of screening applicants for Spanish fluency and interpretation ability, providing training materials to those who qualify, and helping them through the evaluation process during their first few interpreting shifts. As a result, I know many of the clinic's interpreters well, and work with the Health Brigade team to ensure that they, and the patients and providers they work with, have a positive experience at the clinic.

My work coordinating the interpretation program at Health Brigade has been an exciting coalescence of the interpreting experience I’ve had at other free clinics in the Richmond area, as well as my academic focus on health disparities and improving healthcare access. Engagement with Goochland Cares, Crossover Clinic, and VCU Cares, as well as coursework in public health and medical anthropology, has prepared me well to take on the challenge of building a robust interpretation program at Health Brigade. It has been incredibly rewarding to be a part of the growth of what is now a prime example of how medical interpreter volunteers can and should be used in a free clinic setting to improve patient care. I believe that there is currently an enormous potential for growth in the way that free clinics provide interpretation services, and in the rigor with which those services are studied and evaluated. Witnessing the need that exists for high-quality medical interpretation at Health Brigade and free clinics like it inspired this research as an investigation of best practices in providing interpreters, and I hope that my findings could prove useful to other clinics looking to improve the quality of care that they provide to LEP patients.

Medical Interpretation in the United States

Over the past several decades, the United States has experienced a major demographic shift. Immigration has skyrocketed, bringing greater cultural richness and, perhaps most dramatically, linguistic diversity into the nation’s population. Today, of the 328 million people living in the US, 57 million, or 20 percent, speak a language other than English at home (Betancourt, 2012, 3). Of those 57 million, 25 million are defined as having “limited English proficiency,” or speaking English less than “very well.” This means that nearly nine percent of the US population has a limited ability to speak and understand the English language. However, in a significant proportion of US hospitals and clinics, the large majority of physicians speak English exclusively (Moreno, 2010, 414). Clear communication is just as important to the practice of medicine as any drug or diagnostic, and it becomes impossible in the face of even a partial language barrier. Thus, medical interpretation services of some kind are critical for medical professionals to provide high quality healthcare services to all of their patients, regardless of the language they speak.

Interpreting is “the facilitation of spoken or signed language communication between users of different languages” (Sultanic, 2020). Medical interpretation is any interpreting that occurs in a healthcare setting, typically during interactions between a patient and their provider. The American Academy of Family Physicians clarifies that while a medical interpreter’s primary function is to be a “conduit for a discussion, they may secondarily serve as clarifiers, cultural liaisons, or patient advocates” (Juckett and Unger, 2014, 477). A medical interpreter allows a patient and provider who speak two different languages to communicate with one another in clinical settings, but they do much more than that. Interpreters act as brokers of multicultural exchange- clarifying cultural differences when necessary- and as advocates for LEP patients in a system often not designed to accommodate them. This is one of the major reasons why bilingual family members should not act as interpreters in medical settings- intentionally or not they may cloud direct communication between the patient and provider. Without a trained interpreter, patients with limited English proficiency are unable to receive the same medical autonomy and quality of care afforded to their English-speaking counterparts.

Studies have shown that patients with limited English proficiency are more satisfied with the care they receive when they are provided with trained interpreters. For example, the *Hablamos Juntos* initiative which placed nationally certified interpreters in clinics and hospitals across the country found that Spanish-speaking patients who used the interpreters felt that they received better care in three measured categories than those who did not (Moreno and Morales, 2010, 1282). In post-appointment surveys, patients who used *Hablamos Juntos* interpreters felt that their communication with their doctors was 51% better, that office staff were 37% more helpful, and that they were 37% more satisfied with their care overall than those who needed but did not use an interpreter (Moreno and Morales, 2010, 1285). Interpreters provide LEP patients with a more positive communication experience throughout the care process, facilitating discussions with providers and other clinical staff members. Overall satisfaction with care, too, is improved with interpreters, and is critical to developing the trust between patients and their providers that allows for productive clinical encounters.

Beyond a potential for reduced satisfaction with care and negative patient-provider relationships, patients with limited English proficiency are at an increased risk for adverse safety events when not provided with trained interpreters. A study of six Joint Commission-accredited US hospitals found that while only 30% of recorded adverse events involving patients who spoke fluent English led to some form of physical harm, almost 50% of those events involving patients with limited English proficiency caused physical damage (Dobson, 2007, 335). Further, 52% of adverse events involving LEP patients were the direct result of communication-related errors, relative to only 36% for proficient English speakers. A 2012 report by the Agency for Healthcare Research and Quality states that in the absence of “professional interpreters…at admissions and/or discharge,” patients with limited English proficiency stay in the hospital longer than English speakers, and thus are at greater risk for “line infections, surgical infections, falls, and pressure ulcers” (Betancourt, 2012, 3).

Providing interpreters reduces these physical risks for patients, and corresponding financial risks for the hospitals or clinics providing their care. These financial risks can be significant, with one healthcare liability insurer reporting an average of "$2.3 million in damages or settlements and $2.8 million in legal fees for cases where the provider failed to offer a professional interpreter" (Rice, 2014). Nothing less than patient safety is at stake if interpreters are not involved in the care of patients with limited English proficiency, making them a critical part of healthcare infrastructure in the United States. Financial incentives for hospitals and clinics to provide interpreters should also not be overlooked. As Patricia Gavilan, a registered nurse, the Manager of Cross-Cultural Services for the Bon Secours hospital system, and a certified interpreter herself puts it, while high-quality interpretation services are costly, hospitals should consider them "a cost of doing business" (2020). In the United States today, when linguistic diversity is at an all-time high, medical interpreters are just as essential to hospital and clinic operation as blood pressure cuffs, MRI machines, EMR software, and even care providers themselves.

Legal Standards for Medical Interpretation in the United States

As the clear need for trained interpreters in medical settings has grown in the United States, the federal government has passed several laws regarding the use of interpreters in hospitals and clinics that receive federal funding. The first, which has become the foundation for several subsequent laws on the rights of patients with limited English proficiency, was Title VI of the Civil Rights Act of 1964. Title VI states that no one in the US would "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 institution that received any kind of funding or financial assistance from the federal government (Chen et al., 2007, 362). Though the law does not specifically mention language, the Supreme Court has set a precedent that language discrimination is legally equivalent to discrimination based on national origin. In the 1974 case *Lau v. Nichols*, the Supreme Court affirmed the rights of public-school students of Chinese descent in San Francisco to receive supplemental English language courses on the basis that refusal to offer these courses constituted national origin discrimination under Title VI (Oyez, n.d.).

This decision allowed for elaboration on Title VI to further protect people with limited English proficiency in the US through both institutional practice and national policy. In 1980, the Department of Health and Human Services issued a statement asserting that "no person may be subjected to discrimination…in health and human services programs because they have a primary language other than English" (Chen et al., 2007, 363). This includes any hospital or clinic which accepts patients with Medicare or Medicaid, or that receives any NIH or CDC funded grants. Though it did not formally expand Title VI further than *Lau v. Nichols* already had, this statement did explicitly affirm that its tenets apply to federally funded healthcare settings. This affirmation paved the way for the requirement that LEP patients be provided with trained interpreters during medical encounters.

In spite of the laws passed and statements made in the late 20th century, interpretation services only started to become widely available in healthcare settings in the early 2000s, after the passage of then President Bill Clinton's Executive Order 13166 (Gavilan, 2020). The Order stated that "federally conducted and federally assisted programs and activities" should be meaningfully accessible "for persons who, as a result of national origin, are limited in their English proficiency" (Clinton, 2000, 50121). It gave federal agencies a clear responsibility to ensure that their own programs and those of their funding recipients upheld the national origin-related guidelines of Title VI (Chen et al., 2007, 363). This provided a practical framework for enforcement of Tittle VI that had not previously been established, and protected the rights of individuals with limited English proficiency to access interpreters.

The legal imperative for hospitals and clinics to provide interpretation services for their patients has been further expanded in the past decade, since the passage of the Affordable Care Act. Section 1557 of the Act requires that any medical setting which receives federal funding takes “reasonable steps to provide meaningful access to each individual with limited English proficiency who is eligible to be served or likely to be encountered within the entities’ health programs and activities” (Office for Civil Rights, 2015). These reasonable steps, Section 1557 suggests, may include “the provision of language assistance services, such as oral language assistance or written translation” (Office for Civil Rights, 2015). This is a clear, enforceable assertion that interpreters should be provided to LEP patients in federally funded clinical settings. Given the ubiquity of federal funding in the US healthcare system, this is nearly a blanket mandate for interpretation.

Literature Review

The Multiple Roles of Medical Interpreters

From a purely definitional standpoint, an interpreter translates a conversation between two parties who speak different languages. A medical interpreter does so in a clinical setting of some kind. However, medical interpreters are responsible for much more than simply translating dialogue- they are a critical part of the patient care and advocacy team. A 2019 study examined physician perceptions of the roles of medical interpreters in patient interactions (Schwei, et al.).

In semi-structured interviews with eleven primary care pediatricians and family medicine doctors, the authors asked about their experiences with medical interpreters in clinical encounters, and probed further to understand how the physicians viewed interpreters' roles. Drawing from these interviews, the study concluded that, from a provider's point of view, interpreters serve four main purposes: "language conduit, flow manager, relationship builder, and cultural insider" (2). Physicians saw "language conduit" as an interpreter's primary role. As responsibilities associated with this role, they included not only accurate verbal translation but conveying the "nuance and subtlety" of nonverbal communication such as tone and expression (3).

Providers also value medical interpreters as organizers of dialogue or "flow managers." Conversations between two parties who speak different languages, working with an interpreter, can become complex, especially with the level of detailed exchange that happens in medical contexts. Physicians value interpreters' ability to "manage communication by communicating with all parties…to adapt to the needs of the encounter" (Schwei, 2019, 4). Interpreters must ensure that all parties present in an exam room know everything that is being said, just as would happen if they spoke the same language. This can be challenging, but it is also critical to ensure that the provider doesn't miss a detail that could help them care for the patient, and that the patient is not left confused about their health. Interpreters may step in and ask for pauses to translate, or for clarification about something that has been said, and thus help to structure communication in an encounter between a provider and their patient with limited English proficiency.

Several physicians interviewed for the study also noted the role that interpreters can play in enhancing the provider-patient relationship. One explained that "patients, when they feel comfortable with an interpreter…that facilitates the interaction" (4). The providers too often had existing relationships with interpreters, which they felt facilitated their work with them and improved the quality of their communication with LEP patients. The "cultural insider" role was another identified by providers as a critical piece of an interpreter's job in both relationship-building and care quality improvement. An example of this role was given by one provider, who described the following scenario:

> You know I can see if you're, if you're a Hmong interpreter and you have a provider getting frustrated with a family about why they're not getting medication, you know, you might feel that it's gonna help everyone just to say, out of the [exam] room, not necessarily about that family, but to say 'look, just in general, I need you to know that sometimes Hmong families don't take too well to giving medication and it's because of a belief of this.' You know, whatever, you know, is that outside the bounds of a traditional interpreting role? Sure it is, but who else is gonna give that information? (Schwei, 2019, 5).

Indeed, an interpreter is often the only one in the room with dual cultural knowledge as well as dual language fluency, and cultural nuance can be critical to a provider's understanding of their patient.

Several other publications have reinforced Schwei's findings regarding the multiple dimensions of a medical interpreter's role. In a 2010 study of 39 healthcare providers, Hsieh and Hong found that emotional support for both patients and providers was another key facet of an interpreter's work. Some felt that "interpreters' emotional support is implied by their simple presence" as "it's much easier to relate to someone who speaks your own language and maybe make you feel more comfortable" (Hsieh and Hong, 2010, 3). When patients feel this heightened sense of comfort, providers noted, "they may be more willing to provide information or to be receptive to providers' care" (Hsieh and Hong, 2010, 5). Interpreters may also be agents of equity for LEP patients in a healthcare system not designed to work for them. In the past- and even today- medical errors as a result of impaired communication have been deemed "unavoidable or not worth the cost to address" by healthcare institutions (Green and Nze, 2017). LEP patients have been classified as "poor historians" of their own health because they cannot adequately communicate with their provider. However, interpreters can prevent these errors and misinterpretation, moving LEP patients closer to equity with their English-speaking peers. As Elaine Hsieh and Eric Kramer, academic experts on medical interpretation, warn, we must avoid a "conduit model limits interpreters' power by objectifying interpreters as language-transferring machines, a restricted role that silences interpreters' voice" and their capacity to fill so many other roles in encounters with LEP patients (2012, 7).

Modes of Interpretation

In a Joint Commission study of sixty hospitals across the US, 98% reported having telephone interpretation services available or patients with limited English proficiency (Wilson-Stronks and Galvez, 2007, 55). 88% used bilingual staff to communicate with LEP patients, 38% had trained interpreters employed by the hospital, 32% worked with contracting interpreters, and 12% utilized bilingual volunteers. While it is likely that this breakdown has changed in the fourteen years since the study was conducted, Patricia Gavilan reported that in her role as the Manager of Cross-Cultural Services for the Bon Secours health system, she has seen the use of each of these in the hospitals she supervises (2020). Data on the available modes of interpretation in outpatient clinics is harder to come by, but a 2018 study published in *Annals of Family Medicine* reports that in-person, telephone, and video remote interpreting are all used in clinics across the US (Jacobs et al., 72). However, in-person interpreters tend to be significantly more expensive than remote interpreters, making phone and video services an attractive option for many smaller clinics. Indeed, in-person medical interpreters may charge from $45-150 per hour for their work, while phone and video interpreters typically charge between $1.25 and $3.49 per minute (73).

Multiple interpreting modes thus remain common in both inpatient and outpatient medical settings. Large corporations such as Jeenie, Language Line, Cyracom, and Voyce often contract with hospitals and clinics to provide telephone or video interpreting services, while several credentialing bodies have been established to certify in-person interpreters (Gavilan, 2020). As the need for language services in US hospitals and clinics has grown over the past several decades, so has the diversity of ways in which interpreters meet that need. Given the nuances of communication between a healthcare provider and their patient, the imperative to more thoroughly understand how interpreting mode impacts healthcare for LEP patients has become apparent.

Studies of In-Person and Telephonic Interpretation

Many studies on interpretation compare patient and provider satisfaction with clinical encounters where a trained interpreter is used, to those where an interpreter is not used, or where an ad-hoc interpreter is used. Findings from these studies illustrate overwhelmingly that satisfaction with care and quality of care for LEP patients is improved when a trained interpreter is used. However, research on the differences in interpreting modes is more scarce. I found published literature comparing in-person and telephonic interpretation in clinical settings through Google and Pubmed searches for key terms including “interpretation method” “interpreting mode” and “in-person and telephonic interpretation.” My searches returned six studies, published between 2009 and 2021. Study settings varied from outpatient clinics to large, inpatient hospitals, and involved data from patients, providers, and interpreters about interpretation services.

A 2021 study- based on data gathered between 2014 and 2017- examined patient satisfaction with interpretation services provided in-person, over the phone, and through a video call (Pathak et al.). The study was set in a "large urban, academic primary care practice" an included 326 participants who "self-identified as Chinese or Latino" (Pathak et al., 2021, 2). Those participants who required interpretation services were asked in post-appointment phone surveys to rate their satisfaction with their interpreters on a one to five scale. 73.6% of participants used a video interpreter, 15.6% used an in-person interpreter, and 10.7% used an interpreter over the phone. Adjusting for variables including language, age, gender, and education, participants rated their satisfaction with interpreting services at 3.91 for video, 3.86 for in-person, and 3.73 for telephone. The authors concede that their data "do not give us specific information on the exact elements of different interpretation modalities that may have shaped patients' assessments," but conclude that telephone interpreting was likely least preferred because of the nonverbal communication it loses. They speculate that video interpreting may have been preferred over in-person because it improves the "context of who is in the room"- only the patient and their provider (5).

An earlier study similarly investigated patient satisfaction with in-person and telephone interpreters, as well as with bilingual providers as an alternative to interpretation (Crossman et al., 2009). Set in an urban pediatric emergency department where "20% of visits are by families with limited English proficiency," patients were randomized to receive one of the three forms of language services after being identified as having LEP during triage (631). Immediately after their ED visit, patients' families were interviewed about their satisfaction with language services, and their understanding of what the provider had said to them. 34% of patients were randomized to the telephone interpreter group, 31% to the in-person interpreter group, and 35% to the bilingual provider group. The authors found no significant differences between the three groups' understanding of their providers based on analysis of the diagnosis they provided to an interviewer compared to the diagnosis on their discharge report. They did find differences in overall satisfaction with language services, namely that families were more satisfied with an interpreter than a bilingual provider, and more satisfied with phone interpreters than with the in-person interpreter (637).

Few studies focus on interpreter perspectives of different interpreting modes, but one conducted across three hospitals in the San Francisco area did choose to gather data from interpreters themselves (Price et al., 2012). The hospitals included in the study had patient populations in which the prevalence of limited English proficiency ranged from 15 to 46%, and all used telephone, video, and in-person interpreters. 71 participants in the study, all trained interpreters, were asked to complete a survey about their satisfaction with different interpreting modes on a scale from one to five. The authors found that in asking about specific areas of satisfaction with different interpreting modes,

> a large majority of interpreters reported satisfaction with each modality for communicating what the patient said and what the clinician said. However, significantly fewer were satisfied with their ability to establish rapport or facilitate clinician understanding about the patient's cultural or social background via telephonic interpretation compared to in-person (Price et al., 2012, 6).

This result held true for video interpretation, which participants also ranked below in-person interpretation for establishing a strong sense of rapport between the patient and their provider. The authors concluded that interpreters view in-person interpretation as superior for "more nuanced aspects of communication" between patients and providers, while telephonic interpretation was seen as sufficient for “administrative, ancillary, and follow-up clinical care scenarios” (7).

Only one study that I encountered analyzed patient, interpreter, and provider views in various interpreting modes. Set at the post-partum and pediatric clinics of the Medical University of South Carolina, it compared the perceived quality of clinical encounters where interpretation was provided in-person, over the phone, and through video call (Locatis et al., 2010). Over seven months, 241 Spanish-speaking patients were randomly assigned to a rotation of in-person, video, and phone interpretation. They were then asked to rate their experiences with each on a scale from one to five with an option to provide comments, as were the 24 providers and seven interpreters who worked with them. For in-person interpretation, the average patient rating was 4.80, the average interpreter rating was 4.84, and the average provider rating was 4.90 (Locatis et al., 2010, 347). For video interpretation, the average patient rating was 4.85, the average interpreter rating was 4.64, and the average provider rating was 4.58. Finally, for phone interpretation the average patient rating was 4.82, the average interpreter rating was 4.50, and the average provider rating was 4.58. Based on statistical analysis, the authors concluded that “encounters with in-person interpretation were rated significantly higher by providers and interpreters, while patients rated all methods the same,” and that while patients did not rate video and phone interpretation differently, providers and interpreters had a significant preference for video interpretation over phone (345).

From two briefer studies of interpretation, a few additional key points emerge. A 2016 report investigated factors that influence providers’ choice to use ad hoc interpreters- like untrained family members or staff- rather than professional interpreters (Mayo et al.). It included a broad sample of providers from a large health system in South Carolina, for whom work in both inpatient and outpatient settings was common. When asked about these factors, 31% of respondents indicated that "technical difficulties in accessing a qualified medical interpreter by phone or video" was likely to influence them to use an ad hoc interpreter (i.e. a bilingual person not trained as an interpreter) over a trained one (76). The authors conclude that a "lack of awareness surrounding the risks associated with ad hoc interpreters may lead to cutting corners" by providers, and that increasing the efficiency of interpretation services is critical to ensuring the safety of LEP patients (78).

Few studies moved beyond survey scores in analyzing stakeholders' perspectives on interpreting modes, but one additional, more general analysis of providers' views of emotional support provided by interpreters to patients does include some interview and focus group data (Hsieh and Hong, 2010). Providers from five different specialties who worked with patients in both hospital and clinic settings were included in these interviews and focus groups. Several providers in the study felt that phone interpreters could not provide the same level of emotional support as in-person interpreters. One noted that "it's a matter of eye contact, it's a matter of body habitus…sometimes, the family needs to be able to make eye contact, and feel like they are having some human connection" (Hsieh and Hong, 2010, 4). Analyzing these comments, the authors conclude that "on-site interpreters' physical presence is symbolic, representing a caring gesture from the providers. As a result, an on-site interpreter is better than a telephone interpreter "because it implies providers care enough to go through the troubles to find an onsite interpreter" (4).

These six studies draw a range of conclusions about a most effective or preferential interpreting mode for LEP patients and their providers. Of the three studies that collected patient satisfaction data, two found that patients prefer phone interpreters over in-person, while one came to the opposite conclusion (Crossman et al., 2009; Locatis et al., 2010; Pathak et al., 2021). The two studies that included the perspectives of interpreters both noted their clear preference for in-person interpretation over phone interpretation (Price et al., 2012; Locatis et al., 2010). The single study that examined provider satisfaction concluded that they share interpreters' preference for in-person interpretation (Locatis et al., 2010). Additional findings by Mayo et al. and Hsieh and Hong suggest that this may be because providers find in-person interpreters more efficient than those they contact over the phone, or that they may rely on the emotional support that an in-person interpreter can provide to patients (2016; 2010).

	Patient Satisfaction Score		**Interpreter Satisfaction Score**		**Provider Satisfaction Score**	
	In-Person	Telephone	In-Person	Telephone	In-Person	Telephone
Pathak et al., 2021	3.86	3.73	--	--	--	--
Crossman et al., 2009	3.75	5	--	--	--	--
Price et al., 2012	--	--	4.80	3.75	--	--
Locatis et al., 2010	4.80	4.82	4.84	4.50	4.90	4.58

Table 1. Average patient, interpreter, and provider satisfaction scores with in-person and telephonic interpretation across four studies. Scores have been adjusted to fit a five-point scale in studies that did not use one initially. Five represents the highest possible score.

However, the complete reasoning behind these preferences is difficult to pin down as, to my knowledge, no comprehensive qualitative analysis comparing multiple modes of medical interpretation has been conducted. While Hsieh and Hong's 2010 study did draw conclusions based on qualitative data from interviews and focus groups with providers, it focused more broadly on providers' views of the emotional support that interpreters can provide to LEP patients. A thorough analysis of in-person interpretation relative to telephonic interpretation was not undertaken. I hope to begin to fill that gap with this case study, and to elucidate when and why interpreters and providers prefer in-person or telephonic interpretation. I hope that my analysis will provide context to survey-based data collected in prior studies and expand the growing literature base that exists on medical interpretation. It may also help providers and healthcare administrators make informed decisions about the kinds of interpretation services they will offer their LEP patients, and assist in the optimization of existing language services.

Analysis of Interviews

Provider Interviews

I spoke to two providers at Health Brigade, both of whom had worked or volunteered at the clinic for at least two years. When I asked them both what they enjoyed most about their time with the clinic, they immediately cited its patient population. One commented, "I love the population that we work with. I love the fact that this is really, truly a huge section of the marginalized population here in this area, and the fact that they put their trust in us when there is so much distrust in healthcare and in government involvement in healthcare. So, I love being a part of a solution instead of, you know, commenting about the problems" (Provider One). Further, one provider highlighted the unique wraparound services that Health Brigade provides for this marginalized patient population, noting that "it's not just the primary care but the mental health piece, the trans health piece, and a lot of what health outreach does…I just really like how into it we are in the community" (Provider Two). Promotion of equity and formation of community trust are both key elements of Health Brigade's mission, and they are reflected in what its providers value about their work.

These elements are particularly critical in Health Brigade's commitment to patients with limited English proficiency, and this commitment is tested frequently. Provider One commented that “if I have four patients in a four-hour day, normally I only get one English speaker.” Provider Two similarly expressed that they work with LEP patients “every day that I’m here…a little over 50, 60 percent [of my patients]”. When I asked about differences in their experiences caring for patients who spoke English and who had limited English proficiency, Provider One first explained that they endeavor to treat all of their patients with equal respect, regardless of language barriers. “The only difference for me from English to non-English speakers,” they noted, “is it takes a little bit longer.” Provider Two also emphasized issues of efficiency, observing that, “there’s definitely the time piece…because everything has to be said twice. There’s sometimes technology issues based on whatever interpretation app or service you’re using…different when we’re in-person obviously.” Unlike their telephonic counterparts, in-person medical appointments don’t typically have lagging signals or disruptive background noise.

Recounting their experience with various forms of interpretation at Health Brigade, Provider Two laughed and rattled off a long list of services they’d adopted over the years. “I’ve used the Cyracom phone, I’ve used Jeenie, the Voyce, the volunteer interpreters, here and over the phone…everything we’ve tried I’ve utilized.” Asked about telephone interpretation, Provider Two observed first that “on the phone, you know, as long as everybody’s cell service is working okay it’s generally smooth, as long as it’s an interpreter who’s truly competent and fluent.” Yet, to them “in-person [interpretation], for an in-person visit, is always…the gold standard of interpreting, just so much more can be picked up on with that setup.” Provider Two continued, “I think the same piece that’s lost in a telephone visit for providers as far as, like, the ability to see the patient’s body language and non-verbal cues, you know, that’s what’s going on for the interpreter as well, so we’re both kind of at a disadvantage with that with telephone visits, but that's not the case for the in-person so much." Provider One observed a similar loss in their experience with in-person and telephonic interpretation:

> The volunteer interpreters do much, much better in person than they do on the phone. But that's understandable because body language is a huge part of communication. So seeing, you know, the two people trying to communicate is much easier for the interpreter because you can see the transaction between the provider and the patient. So I've found that performance for an interpreter is much, much better when they're with the people…Over the phone I have had stumblings.

Provider One also underscored the impact that an in-person interpreter can have on the openness of communication and subsequent relationship between an LEP patient and their provider: "when there is a human in as your interpreter, the patient can relate a bit more to that individual. This allows for a bit more freer exchange of ideas." Concluding their thoughts, Provider One stated that offered a choice between a telephone and in-person interpreter, "I would always go for an in-person volunteer. Even if they were going to stumble and fumble, I enjoy it so much more and I felt the interpreter learned more, both medically and language-wise. So it's mutually beneficial to all parties. I hated the blue phone [Cyracom]." Provider Two ranked the two options in the same way, asserting that "always if it's somebody [an interpreter] physically here, that's always the best option…so my personal preference would be an in-person body with me, and then a video translate[1], followed by just the audio translation."

I asked both providers to speculate on whether they believed their patients had a preference for in-person or telephone interpreters. Provider Two stated that they "definitely think that they [patients] prefer the in-person [interpreter]. When we had a staff member who was bilingual here who would sometimes help with translating, and those patients had worked with that person before, if I go in the room and I don't have that person they'll be like, 'Hey where are

---

[1] Video interpretation through Voyce's video remote services has gradually become available at Health Brigade in the last three months as an alternative to telephonic interpretation.

they?', you know, they get comfortable." They went on to clarify that "for the patient it [in-person interpretation] is just a little bit more of a human connection so they tend to feel a little more comfortable as opposed to, like, pulling up a stranger on the screen." Provider One was slightly less definite in their answer, explaining that:

> Some of my patients like having the in-person interpreter, however, that being said, most of our interpreters are younger and sometimes…the tone that I have picked up in the patient's voice will change when it's an older individual on the video versus a younger individual in the room. So I'm not sure of the respect and how that changes things, but that's always just at the beginning. Once the younger interpreter, you know, shows competence…it builds rapport.

This sense of rapport between patient, provider, and interpreter is critical to Health Brigade providers' general preference for in-person interpretation over a telephonic alternative. They cite maximization of patient comfort and of open, clear communication as paramount to ensuring that LEP patients receive high quality care, and credit in-person interpretation as the most effective way to reach that goal.[2]

Interpreter Interviews

I interviewed three of Health Brigade's volunteer interpreters, all of whom had undergone a 40-hour training course as medical interpreters through the educational program "Bridging the Gap." They each volunteered for at least four hours per week with the clinic for more than a year, though some have since left their roles. Additionally, each of the interpreters I interviewed had worked with Health Brigade before and after the onset of the COVID-19 pandemic in the spring of 2020, so had experience working as medical interpreters in-person and

---

[2] Fortunately, this preference dovetails with Health Brigade's financial needs. In-person interpretation is free for the clinic, while it must pay on a per-minute basis for telephonic services from a professional interpreting company. During the COVID-19 pandemic, though, volunteer interpreters have also been available for free to the clinic over the phone.

over the phone. I’ve also had this experience in my time as a Health Brigade interpreter volunteer, and am including my own reflections on in-person and telephonic interpretation along with theirs.

When I asked about why they came to Health Brigade, the interpreters I spoke with mentioned similar factors to the providers. Interpreter A explained, “I think that I’m helping people who wouldn’t necessarily be able to get access to care because of their financial situation. I mean that, to me, is good.” Access was especially important to all three interpreters, especially for the LEP patients they work with directly. Interpreter B noted their appreciation for:

> the gratification of knowing that it’s people in the community…It gives me a lot of satisfaction to know that I can help…by not only translating, but if they have to go get a mammogram, okay here’s the letter, here’s what you can expect, and just like being that liaison with them and providing a little bit more information, being sure that they have one place where they can say ‘okay here I can understand the system’ it just give me a lot of satisfaction.

The suite of services that the clinic offers, and that I can help LEP patients access, is also something that stood out to me in my time interpreting at Health Brigade. I’ve been able to help a patient navigate the referral process for a gall bladder surgery, set up an appointment with a psychologist, and arrange behavioral health services to address sleep issues- to name just a few examples. Health Brigade opens all of these doors for its patients, and interpretation allows them to walk through.

Each interpreter, unprompted by me, went on to highlight how much they enjoyed working as an interpreter. Interpreter C called it “one of the most fulfilling things I’ve ever done, and I don’t say that lightly” as “being a bridge between two worlds is pretty cool.” Interpreter B reinforced that sentiment, noting their enjoyment of the nuances of interpretation- “I love that I can…not just provide strict translation but because your culture…and customs have a lot to say with language…it’s just putting all those things together to help provide a good translation.” Yet, this nuanced role does not come without some anxiety, which is something that I personally can certainly attest to. My early days as an interpreter before I came to Health Brigade were often fraught with panic that I might forget a word at a critical moment. As Interpreter A put it, "my favorite parts [of interpreting] are ensuring that whoever is receiving the care is understanding what they're being told…But I think my least favorite part is really just the anxiety of ensuring that I can provide that adequate interpretation, and I think I do a good job but it's definitely still stressful."

This question of adequate interpretation was a theme throughout my interviews with Health Brigade interpreters. Turning our conversations toward their experiences with in-person and telephonic interpretation, Interpreter C noted that:

> When you're interpreting there's little physical cues and body language, you miss out on all of that, not just from the patient but from the doctor as well. All of those little cues, and then also the patient and the doctor miss out on that from us, when we're interpreting or when we're talking…so that was definitely a big part of it.

Important pieces of an adequate interpretative exchange, Interpreter C asserts, are lost when interpretation takes place over the phone. Interpreter A made a similar point about missing body language and emotional cues during telephonic interpretation:

> I think there might be some emotion that is not clear, because like you can hear someone and you can hear what they're saying, but you're losing part of what they're saying from their visual features, like understanding the full context of what they're trying to tell you. I think it also kinda depersonalizes people a little bit…I just think the more important thing is not really being able to see their expressions or their mannerisms when they're speaking.

Given that interpreters in clinical settings are not only linguistic conduits but cultural brokers and patient advocates, and that they are responsible for interpreting tones and feelings as well as words, body language and emotion are critical. Interpreter B further noted the practical importance of the kinds of signals that are only easily relayed in person, observing that "it's easier to clarify when you can, with body language, tell the person 'I need you to pause so I can ask something.'" Knowing when to pause an encounter for clarification is a critical skill for interpreters, and can be one of the most difficult. In my time managing interpreters at Health Brigade, it's something that we send frequent reminder emails about, and that I sometimes struggled with while I was an interpreter. It became especially difficult over the phone when I couldn't raise a hand or change my expression to signal the patient or provider, and occasionally had to step in and interrupt verbally in the middle of an extended monologue.

Another issue that the interpreters all noted with telephonic interpretation was reception inconsistency. Interpreter C explained that "sometimes the connection was a little off whether it was my phone, or their phone, or maybe both." Disruptions in volume or a signal that cuts in and out can make interpreting almost impossible, and are particularly frustrating to the individual who is in charge of ensuring accurate translation of dialogue. I experienced these issues myself, and found my telephonic interpreting encounters sometimes taking longer than those that were in-person as I was forced to ask patients and providers to repeat themselves, or to repeat myself if my reception was spotty. Interpreter B expanded their commentary to patients and providers, describing how "many times while we were trying to do over-the-phone interpreting the system failed very often, so that was very frustrating to them." In my experience, many of these system failure problems were resolved over time as the clinic adjusted to a telephone interpreting model, but reception issues never entirely went away. As Interpreter A summarized, "there's problems with reception, there's just the problems that come with technology…that's probably the worst thing, I think it's a lot easier to understand someone in person."

Though the interpreters I spoke to preferred in-person interpretation to telephonic for a variety of reasons, Interpreter A did mention a few advantages to working over the phone:

> I think there's pros and there's cons because, you know, when you are on the telephone you get up, you sit wherever you want, you can sit down comfortably…you've got like a

> workspace. But I think sometimes it can be hard to figure out the workspace in a small room sometimes. Like trying to stand in the perfect spot, you know…I think that's something that's nice in a way, and also being able to write notes, because I think sometimes people would feel uncomfortable if you're writing notes [in-person].

Though parts of the communication between interpreter, patient, and provider are lost when working over the phone, interpreters are able to work wherever and however they choose. Notes can be an essential tool for interpreters, but may make patients who see them wary, especially the kinds of vulnerable patients that clinics like Health Brigade serves. Further, I've also experienced the reduction in discomfort when interpreting over the phone that Interpreter A describes. I found myself relaxing when working from home at my own desk, which may have increased the ease with which I communicated with patients and providers.

Ultimately, though, all three interpreters felt that the benefits of in-person interpretation outweighed the downside. One of the most important benefits to Interpreters A and C was the relationship-building that in-person interpretation facilitates with LEP patients. Interpreter C explained:

> Some patients come here every three months, and if you're a volunteer for, let's say, a year, then you end up seeing those patients repeatedly. Via telehealth those patients don't really recognize you unless they hear your voice and are able to recognize your voice but in an in-person clinic setting when you see the patient and they recognize you as well, you can kind of build that relationship because the second time they come they can say 'oh I remember you, you were here for my last one' and there's already a sense of trust built in right from the get-go, and that trust is super important because a lot of people are wary of…the health clinic, especially if they don't know English and they're wary of, you know, navigating a world where they don't understand anything…it's harder to establish that kind of relationship over telehealth.

Indeed, they concluded, "even if you only see them once you still maintain a better relationship and interaction overall." This kind of trusting relationship is well-established as critical between providers and their patients, but is additionally important between interpreters and the LEP patients they serve. An interpreter must faithfully communicate the confidential information that a patient shares in full to their provider, and vice versa, so trust is essential. Interpreter C argues, and I agree from my own experience, that in-person encounters are uniquely suited to build that trust. Interpreter A also concurs, sharing their thoughts on relationship-building between patients and their interpreters:

> I think it [having an in-person interpreter] does add a lot more to the connection between the patient and the interpreter…From my perspective because I'm the interpreter I know that there is an impact on the patient, the interpreter being in the room and the interpreter being able to, you know, act as a bridge between two people. I think that it makes it a lot more personalized. I think that the patient feels a lot happier knowing there's an interpreter in the room and seeing them physically…I mean people always smile when they see me.

In sum, these Health Brigade interpreters sense increased feelings of comfort and trust- both fundamental to a positive and productive clinical encounter- in their LEP patients when interpreting in-person.

Conclusion

High-quality medical interpretation is critical to ensuring that patients with limited English proficiency, a rapidly growing group in the US, receive equitable care. Today, as federally-funded hospitals and clinics are legally required to offer language services, a myriad of interpretation options are available and used by providers across the country, including both telephone and in-person interpreters. Though these two options both allow for translation of dialogue between patients and providers, they differ in the communicative and interpersonal experiences they offer. From the perspectives of the providers and interpreters I interviewed at Health Brigade, a community-focused free clinic in Virginia, telephone interpretation may offer interpreters more flexibility in their work environment, and older professional interpreters from phone interpreting companies may garner more immediate respect from patients. However, in-person interpretation avoids the technological pitfalls that can come along with working over the phone, allows for non-verbal communication through body language and facial expressions, and facilitates relationship-building between patients, interpreters, and providers. These benefits were viewed as much more valuable to the patient experience than those of telephonic interpretation, leading to an overall preference for in-person interpretation among the providers and interpreters I spoke with.

Of course, my sample size was small in this study. With more time and resources, I'd love to expand my investigation to providers and interpreters working in other medical environments, potentially including inpatient hospitals and outpatient clinics where LEP patients are less commonly encountered, to better understand the reasons behind interpreting mode preferences in different contexts. My findings also raised several more specific questions that warrant further study. How does an interpreter's age impact their communication with patients? Are there ways to make patients more comfortable with interpreter note-taking at in-person appointments? How does using one interpreter for a patient over multiple appointments affect their relationship and care experience? Each of these questions could shed light on how the healthcare system in the US can better meet the needs of LEP patients, which is a crucial issue as the nation becomes more and more linguistically diverse. Ultimately, I hope that my conclusions from this investigation begin to illuminate the benefits and drawbacks of different interpreting modes for the patient, provider, and interpreter experience, and that they spark discussions among medical providers on how they can best provide equitable care to all their patients, whether they speak English or not. Open and clear communication is foundational to healthcare in any form, and effective interpretation can make it possible for every patient that the US healthcare system serves.

Appendix A: Provider Interview Guide

1. How long have you worked at Health Brigade, and what has your role been in that time?
2. What do you like most about working at Health Brigade?
3. What drew you to work at Health Brigade?
4. How often do you work with patients who have limited English proficiency?
5. How is working with LEP patients different from working with English-speaking patients? What do you find are the challenges or successes you've faced in with working with patients with limited English proficiency?
6. What has your experience working with interpreters been like?
7. How have your experiences working with in-person and telephone interpreters been different?
8. Do you feel like using an in-person interpreter rather than a telephone interpreter has an impact on your interactions or relationship with a patient?
9. Do you have a preference for using an in-person or telephone interpreter? Why?
10. Do you think your patients have a preference for using an in-person or telephone interpreter? Why?
11. Is there anything else you'd like to discuss about your experience working with interpreters at Health Brigade?

Appendix B: Interpreter Interview Guide

1. How long have you worked at Health Brigade, and what roles have you held?
2. What do you like most about working at Health Brigade?
3. Did you have interpreting experience or training prior to working at Health Brigade?
4. What drew you to work as an interpreter at Health Brigade?
5. What has your experience working as an interpreter at Health Brigade been like?
6. What have been the biggest challenges you've faced in your work as an interpreter at Health Brigade?
7. How have your experiences working as an in-person and telephone interpreter been different?
8. Do you feel like interpreting in-person rather than over the phone has an impact on your relationship with the patient and provider? On the patient-provider relationship?
9. Do you think patients and providers have a preference for using in-person or telephone interpreters? Why?
10. Is there anything else you'd like to discuss about your experience working as an interpreter at Health Brigade?

References

Betancourt, Joseph R, et al. *Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals*. U.S. Dept. of Health and Human Services, Agency for Healthcare Research and Quality, 2012.

Chen, Alice Hm, et al. "The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond." *Journal of General Internal Medicine*, vol. 22, no. S2, 2007, pp. 362–367., doi:10.1007/s11606-007-0366-2.

Clinton, Bill. "Executive Order 13166." *Federal Register*, vol. 65, no. 159, 16 Aug. 2000.

Copeland, George. "Health Brigade Establishes Virginia's Second Needle Exchange Program in Richmond." *RVA Mag*, 17 Oct. 2018, rvamag.com/news/health-brigade-establishes-virginias-second-needle-exchange-program-in-richmond.html.

Crossman, K. L., et al. "Interpreters: Telephonic, In-Person Interpretation and Bilingual Providers." *Pediatrics*, vol. 125, no. 3, 16 Oct. 2009, doi:10.1542/peds.2009-0769.

Darnell, Julie S. "Free Clinics in the United States: A Nationwide Survey." *JAMA Internal Medicine*, vol. 170, no. 11, 14 June 2010, pp. 946-953.

Demeria, Katie. "Fan Free Clinic Becomes Health Brigade; Changes Name for First Time in 50 Year History." *Richmond Times Dispatch*, 23 June 2016, richmond.com/business/fan-free-clinic-becomes-health-brigade-changes-name-for-first-time-in-50-year-history/article_6161a357-7510-51b4-9bf3-496f1765ed5a.html.

Dobson, Roger. "US Hospital Patients with Poor English Have More Serious Adverse Events than Proficient Speakers." *BMJ*, vol. 334, no. 7589, 2007, doi:10.1136/bmj.39125.457535.94.

Edwardson, Kaitlin. "Celebrating 50 Years of Health Brigade." *RVA Magazine*, 12 Mar. 2020, rvamag.com/gay-rva/celebrating-50-years-of-health-brigade.html.

"FAQs for Healthcare Professionals." *National Council on Interpreting in Health Care*, www.ncihc.org/faqs-for-healthcare-professionals.

Gavilan, Patricia. Interview. Conducted by Lucy Cummins, 28 Oct. 2020.

Giddens, Theron. "All About Equity." *Richmond Magazine*, Target Communications, 3 Feb. 2019, richmondmagazine.com/news/sunday-story/all-about-equity/.

Green, Alexander R., and Chijioke Nze. "Language-Based Inequity in Health Care: Who Is the 'Poor Historian'?" *Journal of Ethics*, American Medical Association, 1 Mar. 2017, journalofethics.ama-assn.org/article/language-based-inequity-health-care-who-poor-historian/2017-03.

Health Brigade. 2021. https://www.healthbrigade.org/.

"Health Brigade, formerly Fan Free Clinic, turns 50 in 2020!" 2 Jan. 2020. *YouTube*, www.youtube.com/watch?v=bgd2FgNfqbI.

Hsieh, Elaine, and Eric Mark Kramer. "Medical Interpreters as Tools: Dangers and Challenges in the Utilitarian Approach to Interpreters' Roles and Functions." *Patient Education and Counseling*, vol. 89, no. 1, Oct. 2012, pp. 158–162., doi:10.1016/j.pec.2012.07.001.

Hsieh, Elaine, and Soo Jung Hong. "Not All Are Desired: Providers' Views on Interpreters' Emotional Support for Patients." *Patient Education and Counseling*, vol. 81, no. 2, Nov. 2010, pp. 192–197., doi:10.1016/j.pec.2010.04.004.

Huang, Jennifer, et al. *Talking With Patients*. George Washington University, Aug. 2009.

"Is Your Hospital Compliant with These Five Language Interpretation Requirements?" *Intelligere Solutions*, Intelligere, 2 Aug. 2019, intelligeresolutions.com/is-your-hospital-compliant-with-these-five-language-interpretation-requirements/.

Jacobs, Barb, et al. "Medical Interpreters in Outpatient Practice." *The Annals of Family Medicine*, vol. 16, no. 1, 2018, pp. 70–76., doi:10.1370/afm.2154.

Juckett, Gregory, and Kendra Unger. "Appropriate Use of Medical Interpreters." *American Family Physician*, vol. 90, no. 7, 1 Oct. 2014, pp. 476-480.

Lee, Nelva. "Certified Medical Interpreter Salary & How Much They Get Paid." *MiTio*, 12 Aug. 2020, www.mitio.org/blog/certified-medical-interpreter-salary-how-much-they-get-paid-mitio.

Locatis, Craig, et al. "Comparing In-Person, Video, and Telephonic Medical Interpretation." *Journal of General Internal Medicine*, vol. 25, no. 4, 27 Jan. 2010, pp. 345–350., doi:10.1007/s11606-009-1236-x.

Low, Setha M., and Sally Engle Merry. "Engaged Anthropology: Diversity and Dilemmas." *Current Anthropology*, vol. 51, Oct. 2010.

Mayo, Rachel, et al. "Cutting Corners." *Hispanic Health Care International*, vol. 14, no. 2, 2016, pp. 73–80., doi:10.1177/1540415316646097.

Moores, Carrie. "Surprising Facts About Free Clinics." *Barrier Islands Free Medical Clinic*, 30 Jan. 2021, www.bifmc.org/surprising-facts-about-free-clinics/.

Moreno, Gerardo, and Leo S. Morales. "Hablamos Juntos (Together We Speak): Interpreters, Provider Communication, and Satisfaction with Care." *Journal of General Internal Medicine*, vol. 25, no. 12, 2010, pp. 1282–1288., doi:10.1007/s11606-010-1467-x.

Moreno, Gerardo. “Self-Reported Fluency in Non-English Languages Among Physicians Practicing in California.” *Family Medicine*, vol. 42, no. 6, June 2010, pp. 414–420.

Office for Civil Rights. "Section 1557 of the Affordable Care Act." *HHS Civil Rights*, 12 Nov. 2015, www.hhs.gov/civil-rights/for-individuals/section-1557/summary/index.html.

Oyez. “Eisenstadt v. Baird.” n.d. https://www.oyez.org/cases/1971/70-17.

Oyez. “Lau v. Nichols.” n.d. https://www.oyez.org/cases/1973/72-6520.

Pathak, Sarita, et al. “Patient Perspectives on the Quality of Professional Interpretation: Results from LASI Study.” *Journal of General Internal Medicine*, 29 Jan. 2021, doi:10.1007/s11606-020-06491-w.

Price, Erika Leemann, et al. “Interpreter Perspectives of in-Person, Telephonic, and Videoconferencing Medical Interpretation in Clinical Encounters.” *Patient Education and Counseling*, vol. 87, no. 2, May 2012, pp. 226–232., doi:10.1016/j.pec.2011.08.006.

Rice, Sabriya. “Hospitals Often Ignore Policies on Using Qualified Medical Interpreters.” *Modern Healthcare*, 30 Aug. 2014, www.modernhealthcare.com/article/20140830/MAGAZINE/308309945/hospitals-often-ignore-policies-on-using-qualified-medical-interpreters.

Schwei, Rebecca J., et al. “Physician Perceptions of the Types of Roles Interpreters Play in Limited English Proficient Pediatric Encounters and How They Evaluate the Quality of Interpretation.” *Primary Health Care Research & Development*, vol. 20, 2019, doi:10.1017/s1463423618000890.

Sultanic, Indira. *Introduction to Medical Interpreting*. Sept. 2020.

Virginia Association of Free and Charitable Clinics (VAFCC). "About Free Clinics." *Virginia Association of Free and Charitable Clinics*, 2021, www.vafreeclinics.org/about-free-clinics.

Wilson-Stronks, Amy. The Joint Commission, 2007, *Exploring Cultural and Linguistic Services in the Nation’s Hospitals: A Report of Findings*, www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/assetmanager/hlc_paperpdf.pdf?db=web&hash=8037302668AE999AC7C1DBC01DCBE821.