

Provider, patient, and interpreter perspectives on remote medical interpreting: a mapping review

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Introduction

- In the USA, 9% of the total population speak English less than “very well” and qualify as limited—English proficient (LEP)¹
- With remote medical interpreting (RMI) infrastructure already in place after a massive uptake during the COVID-19 pandemic, it should receive further attention so that it may continue serving LEP populations best

Objective and Significance

- Patients who are LEP have an increased risk of miscommunication with the healthcare team, leading to poorer health outcomes²
- The purpose of this study is to identify common drawbacks and solutions directly reported by key participants in RMI encounters over a twenty-three-year period (2002-2025) to determine a shared direction for future improvement

Results

- Hardware and software issues were most prevalent, including but not limited to: device functioning, connectivity, audio quality, visual quality, and spatial arrangement of hardware (camera, microphone) for optimal use (Figure 2, n=12)
- Training, education, and etiquette issues were reported by interpreters, patients, and providers alike (n=9)
- Feelings of decreased overall translation quality were commonly reported by interpreter-side studies. Patient-side studies concurred, citing feelings of not being heard or understood properly without an in-person interpreter (n=9)
- Issues building a sense of personal/professional connection with the other parties present due to a lack of visual contact, in-person presence, or team acknowledgement (rapport issues) was a major response from interpreter-side studies (n=8)
- Interpreter-side studies uniquely highlighted inadequate pre-session briefing by the provider (n=3)
- The most common preference recommended by all parties was maintaining visual contact with the other parties present, whether by video or in-person (n=12)

Conclusions

- This mapping review identified three important trends across the RMI literature:
- 1) a strong preference for visual contact shared by all parties
 - 2) interpreter-specific desire for group inclusion (more briefing, sense of rapport, digital etiquette),
 - 3) a call for increased clinician training, education, and exposure to RMI
- A clinician who is familiar with in-house technology, ensures satisfactory visual and audio quality of both parties, establishes a comfortable pattern of communication, and briefs the interpreter appropriately can effectively solve most shared drawbacks of RMI
 - Clinician training initiatives with these considerations in mind should be the shared priority moving forward for smoother, more fruitful RMI encounters.

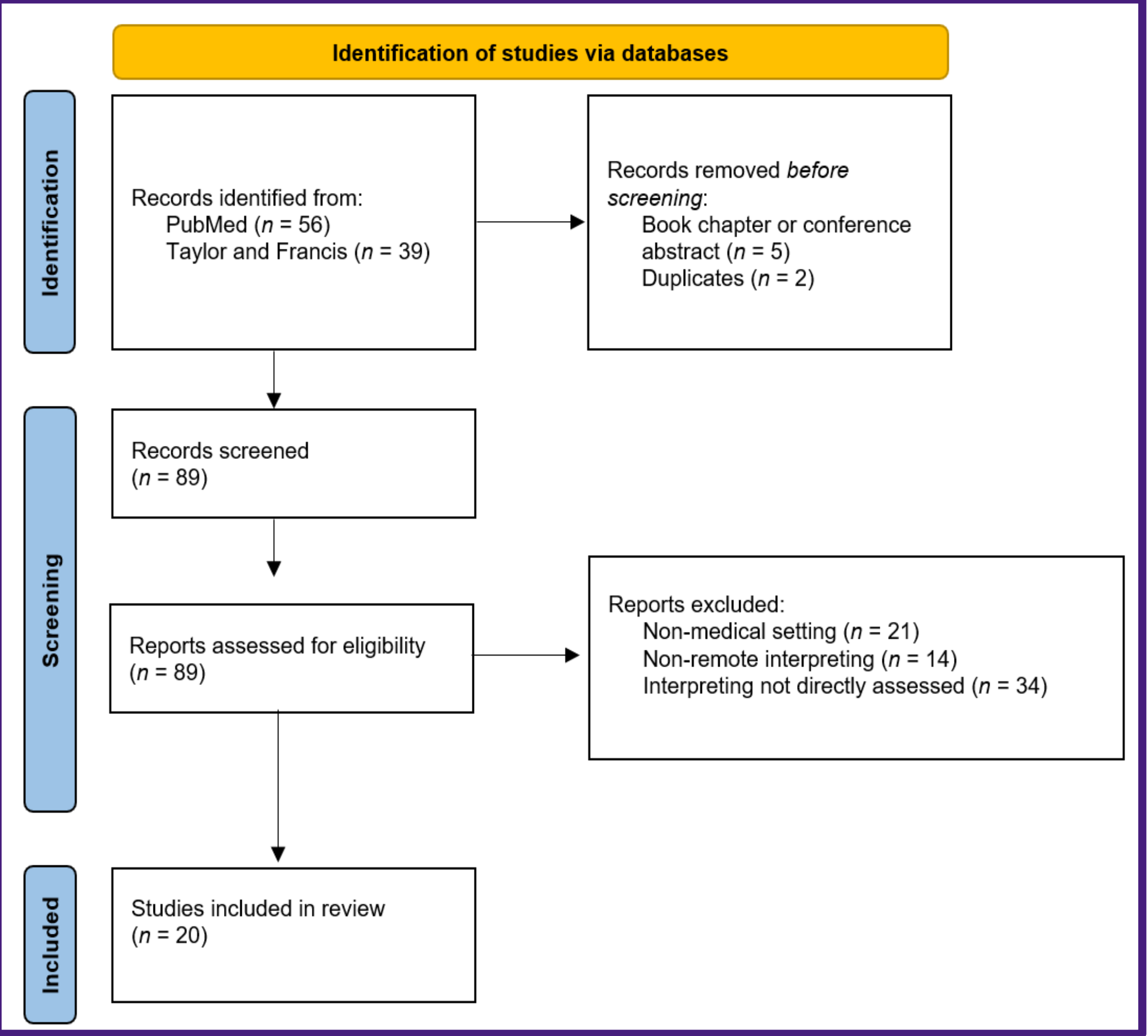


Figure 1: PRISMA 2020 flow diagram depicting the literature selection process

Methods

- A systematic search was conducted using the databases PubMed and Taylor and Francis Online for abstracts published between January 1, 2002 and December 31, 2025
- Boolean search terms included "remote medical interpreting" and "remote interpreting" and "video interpreting" and "telephone interpreting". Duplicates, book chapters, and conference abstract were removed before screening (Figure 1)
- The remaining results were screened based on the following three criteria: involves interpreting in a medical setting, involves remote interpreting, and directly assessed the interpreting taking place. Twenty studies were identified (Figure 1)
- Studies were separated into three overlapping categories based on the perspectives involved: interpreter (orange), patient (green), and/or provider/clinician (blue) (Figure 2)
- The common issues identified were technological issues, lacking training/education, lowered rapport, inadequate briefing, and/or overall translation issues. The common solutions proposed were clinician training, interpreter training, patient education, equipment improvement, and/or securing visual contact (Figure 2)

1st Author (year)	Perspectives/input			Modality		Issues mentioned					Solutions recommended				
	Interpreter	Patient	Provider	Telephone	Video	Tech/audiovisual/co nnection issues	Training/Education /Etiquette	Rapport issues	Briefing	Overall translation quality	Clinician training	Interpreter training	Patient awareness	Improve/maintain equipment	Prioritize in-person/video over telephone
Zhang et al (2023)	✓	—	—	✓	✓	✓	✓	✓	✓	✓	✓	—	✓	✓	—
Klomfar et al (2025)	✓	—	—	—	✓	✓	—	✓	✓	✓	✓	—	✓	✓	—
Cho et al (2023)	✓	—	—	✓	—	✓	✓	✓	✓	✓	✓	—	—	—	✓
Price et al (2012)	✓	—	—	✓	✓	—	—	✓	—	—	—	—	—	—	✓
Kostareva et al (2023)	✓	✓	—	—	✓	✓	✓	✓	—	✓	✓	✓	—	—	✓
Hieke et al (2025)	—	✓	—	✓	—	✓	—	✓	—	✓	—	—	✓	—	—
Guzman et al (2025)	—	✓	—	✓	✓	✓	—	—	—	—	—	—	✓	—	✓
Myers et al (2022)	—	✓	—	—	✓	✓	—	—	—	—	—	—	—	—	✓
Schulz et al (2015)	—	✓	—	✓	✓	—	—	—	—	—	—	—	—	—	✓
Jaiteh et al (2022)	—	✓	—	✓	—	—	—	—	—	✓	—	—	—	—	✓
Kushalnagar (2019)	—	✓	—	—	✓	✓	✓	—	—	✓	—	✓	—	—	✓
Fielder et al. (2022)	—	✓	✓	✓	✓	—	—	—	—	—	—	—	—	—	✓
Yabe (2020)	—	✓	✓	—	✓	✓	✓	✓	—	—	✓	✓	✓	✓	✓
Larsen et al. (2025)	—	—	✓	✓	✓	—	✓	—	✓	✓	✓	—	—	—	—
Pavill (2019)	—	—	✓	—	✓	—	✓	—	—	—	✓	—	—	—	—
Marshall et al. (2019)	—	—	✓	—	✓	✓	—	—	—	—	✓	—	—	✓	✓
Pruskil et al. (2023)	—	—	✓	—	✓	—	✓	—	—	—	✓	—	—	—	✓
Saeki (2022)	—	—	✓	—	✓	—	—	—	—	✓	—	✓	—	—	—
Jones et al. (2003)	✓	✓	✓	✓	✓	✓	—	—	—	—	—	—	—	—	—
Klammer et al. (2021)	✓	✓	✓	—	✓	✓	✓	—	—	—	✓	—	—	—	—
						12	9	8	4	9	10	4	5	4	12

Figure 2: Table depicting the modalities, issues, and solutions mentioned in each study, grouped by included perspectives (orange = interpreter, green = patient, blue = provider, red = all three)

Discussion

- Decreased translation quality was noted most frequently by interpreters themselves. They often felt unable to observe patient language and gestures across the remote modality and thus unable to convey them to the provider (Figure 2)
- Training, education and etiquette issues were prevalent, ranging from suboptimal use of technology, incorrect or unprofessional utilization of interpreters, or lack of proper digital communication techniques (speech overlap, interruptions, unidentified speakers, etc.).
- Interpreters noted difficulties forming rapport with the patient and provider due to the remote modality. This often occurred due to a lack of visual contact, in-person presence, or team acknowledgement, and was a key issue shared by all interpreter-side studies
- Maintaining visual contact was a top priority for interpreters and patients especially
- Both interpreter and provider-side studies called for increased provider training as a solution to these problems

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