The Hidden Roles of Healthcare Interpreters

by

Marisa Rueda Will

A Thesis

Submitted to

Western Oregon University

In Partial Fulfillment of the Requirements

for the Master of Arts Degree in Interpreting Studies

June 2026

MASTER'S DEGREE FINAL EVALUATION REPORT

Completion Term: Spring 2026

Type of exit requirement: Thesis

The supervisory committee met with the candidate for a final evaluation in which all aspects of the candidate's program were reviewed. The committee's assessment and recommendations are:

Recommendations:

- ✓ Degree should be awarded

Recommendations:

- ✓ Exit Requirement has been approved

Acknowledgements

I would like to thank Dr. Elisa Maroney, my committee chair and sounding board over the last two years. Her guidance, feedback, and research expertise enriched this study in ways I could not have accomplished on my own. I am especially grateful that this was the last thesis Dr. Maroney oversaw as a committee chair before concluding a 33-year career at Western Oregon University in the Division of Deaf Studies and Professional Studies. Her final words of advice to me were, “There is still so much work in the interpreting world to be done.”

I would also like to thank my committee members, Professors Elizabeth Jean-Baptiste and Amanda Smith, for taking the time to read this work and engage in scholarly discussion throughout the process. Their insights and perspectives helped strengthen this study and challenged me to make it the best contribution possible to the healthcare interpreting profession.

A special thank you to my cohort of colleagues who spent the last two years learning, growing, and navigating this journey alongside me. Your support, encouragement, and camaraderie made the experience far less lonely.

To my husband, Adam, and our four children for believing in me more than I ever could, and for being my purpose, always.

Finally, this work is dedicated to the patients with limited English proficiency who deserve to be heard, understood, and driving change around language access enhancements. And, finally, to the healthcare interpreters who make a difference in patients' lives every single day simply by showing up and doing the work.

Table of Contents

List of Figures

List of Tables

Abstract

The Hidden Roles of Healthcare Interpreters

By

Marisa Rueda Will
Master of Arts in Interpreting Studies
Western Oregon University
June 2026

Healthcare interpreters play a critical role in facilitating communication between limited English proficient (LEP) patients and healthcare providers. While professional standards traditionally emphasize linguistic mediation, interpreters often perform additional functions that influence patient experiences, provider communication, and healthcare delivery. This study examined the extent to which healthcare interpreters engage in activities beyond linguistic message transfer and explored how these activities are perceived by interpreters, healthcare providers, and Spanish-speaking LEP patients.

Using a mixed-methods survey design, quantitative and qualitative data were collected from healthcare interpreters (n = 159), healthcare providers (n = 19), and Spanish-speaking LEP patients (n = 15). Survey responses were analyzed to identify activities performed beyond language interpretation and to examine stakeholder perspectives regarding the appropriateness and value of these contributions.

Findings indicated that interpreters frequently engaged in activities such as providing emotional support, facilitating patient understanding, contributing cultural and linguistic insights, and assisting patients in navigating healthcare experiences. While respondents across all three groups generally recognized the value of these contributions, perspectives differed regarding

professional boundaries and the appropriate scope of the interpreter role. The findings suggest that healthcare interpreters occupy a complex position within healthcare encounters that extends beyond traditional role definitions and may contribute to communication, patient experiences, and language access outcomes.

Keywords: Healthcare interpreters, language access, patient advocacy, care coordination, cultural mediation, LEP patients, health disparities.

Chapter 1: Introduction

Healthcare interpreters are specialized members of the care team who facilitate critical communication between limited English proficient (LEP)[1] patients and healthcare providers. While artificial intelligence and machine translation have advanced rapidly, these technologies lack the ability to navigate complex medical conversations that require cultural mediation, ethical decision-making, and emotional intelligence (Barwise & Pickering, 2022).

Numerous studies have analyzed the correlation between healthcare interpreters and patient satisfaction, clinical outcomes, and cost reduction. Research shows that professional interpreters, meaning bilingual individuals who have received interpreter training and/or passed interpreting skills tests, contribute to shorter hospital stays, reduced medical errors, and improved quality of care for LEP patients (Flores et al., 2012; Lindholm et al., 2012; Karliner et al., 2017). However, additional research is needed to systematically document the broader contributions of healthcare interpreters within the healthcare system (Joseph et al., 2018).

Beyond linguistic mediation, healthcare interpreters frequently engage in activities that resemble case management, patient navigation, and patient-provider liaison work. In a qualitative study of interpreters working in integrated primary care settings, interpreters described supporting patients through ongoing relationships, helping address barriers to care, facilitating communication across encounters, and contributing to continuity of care through trust-building

[1] The term *Limited English Proficient (LEP)* is used throughout this study because it remains the terminology employed in U.S. federal language access laws, healthcare regulations, and much of the healthcare interpreting literature. The author recognizes that some scholars have criticized LEP as a deficit-based construct that frames language diversity in terms of limitation rather than preference or multilingual ability. Alternative terms include *Non-English Language Preference (NELP)*, *patients requiring interpreter services (PRIS)*, *individuals with language access needs*, and *multilingual individuals*. Consistent with the terminology used in the study instruments and relevant policy frameworks, LEP is retained throughout this study while acknowledging ongoing discussions regarding more strengths-based and person-centered language (Ortega et al., 2022; Youdelman, 2024).

and relationship development (Plys et al., 2024). Despite growing recognition of these contributions, interpreter roles beyond linguistic message transfer remain underrepresented in much of the healthcare and language access literature.

Studies that have started the work of pinpointing the scope of interpreter contributions beyond message transfer tasks alone have identified that interpreters aid with clarifying clinical concepts and providing emotional support (Hsieh & Kramer, 2012; Latif et al., 2022; Suarez et al.; 2021). Similarly, Plys et al. (2024) found interpreters to be linked to trust within encounters, referring to them as "trusted points of contact" who assisted with a host of tasks ranging from "reviewing treatment options, care coordination, and case management (e.g., booking referrals, appointments, problem solving social needs) (p. 11).

Existing frameworks, such as the division of an interpreter's duties into different roles, categorize interpreters as bilingual message transfers specialists who maintain speakers' accuracy and autonomy, cultural mediators, and ethical decision-makers; however, these classifications oversimplify the diverse, high-impact tasks interpreters perform daily (Beltran Avery, 2001; Certification Commission for Healthcare Interpreters [CCHI], 2022). Hospitals vary in how language access requirements are implemented despite federal protections under Title VI and ACA Section 1557 (Youdelman, 2024). Federal enforcement actions continue to identify deficiencies in implementation, including failures to provide qualified interpreters, inadequate staff training, and reliance on family members for interpretation services (U.S. Department of Health and Human Services, Office for Civil Rights, 2016; U.S. Department of Justice, 2024).

In this study, I explore the roles that healthcare interpreters perform beyond linguistic message transfer and examine how these tasks contribute to healthcare system efficiency,

provider workflow, and equitable patient care. By investigating these often-overlooked responsibilities, I seek to highlight the broader integration of interpreters within the healthcare system and their collaboration with providers to ensure effective care delivery.

Background

Research on the effectiveness of interpreting modalities presents mixed results. While some studies indicate higher patient satisfaction with in-person interpreters, others find comparable satisfaction across in-person, over-the-phone (OPI), and video-remote (VRI) interpreting, with slight variations depending on the urgency and complexity of the medical encounter (Joseph et al., 2018).

Given the persistent disparities among LEP populations—exacerbated by the COVID-19 pandemic (Chipman et al., 2024; Giglio et al., 2022)—legal mandates have been established to ensure equitable language access. Under ACA Section 1557, healthcare institutions must provide language access services free of charge, accurately, and in a timely manner while ensuring patient privacy and decision-making autonomy (Youdelman, 2024).

To meet legal requirements and improve communication quality, some healthcare institutions hire in-house interpreters. These interpreters often develop stronger relationships with both providers and patients, offering continuity of care that may not be possible with external or remote interpreters. Even with the increasing professionalization of healthcare interpreting—evidenced by national certification exams—some medical professionals still do not perceive interpreters as integral members of the healthcare team (Ono & Yang, 2024). Furthermore, studies indicate that while linguistic competency is essential, interpreters who lack soft skills—such as cultural competence, emotional intelligence, and adaptability—provide

lower-quality service compared to colleagues who possess these interpersonal skills (Crane, 2022).

Despite these insights, research has yet to fully examine the role of healthcare interpreters, regardless of their institutional employment status, play in enhancing healthcare system efficiency and supporting provider workflow beyond linguistic mediation.

Although value-based healthcare frameworks emphasize patient outcomes, quality of care, care coordination, and patient experience, healthcare organizations frequently continue to evaluate services through productivity, utilization, and financial performance measures (Hempel et al., 2021; Teisberg et al., 2020). Consequently, contributions that improve communication, facilitate care coordination, enhance patient trust, and support continuity of care may be overlooked when they are not easily captured through traditional metrics. This challenge is particularly relevant for healthcare interpreters, whose work is often measured by encounter volume and language access provision rather than by their broader contributions to patient care and healthcare delivery.

This challenge raises important research questions regarding the role of healthcare interpreters within modern healthcare systems. Beyond facilitating communication, what contributions do healthcare interpreters make to patient care, provider workflow, and healthcare delivery? How do interpreters, healthcare providers, and patients perceive these contributions? To what extent do healthcare interpreters engage in activities beyond linguistic mediation, such as cultural mediation, emotional support, care coordination, and patient advocacy? How do interpreters navigate the ethical tensions that arise when patient needs appear to conflict with traditional expectations of professional neutrality? Finally, are important aspects of interpreter

work overlooked by existing measures of productivity, performance, and value within healthcare organizations?

Statement of the Problem

Even with growing recognition of the importance of language access in healthcare, existing research primarily focuses on error reduction, shorter hospital stays, and modality comparisons (Flores et al., 2012; Joseph et al., 2018; Lindholm et al., 2012). However, these studies fail to capture the full scope of in-person healthcare interpreters' contributions, particularly their role in guiding patients through complex healthcare systems, fostering trust between providers and LEP patients, and enhancing overall patient experience. Without research that asks the right questions, the value of interpreters remains underrepresented in policy discussions, limiting their integration as essential members of the healthcare team.

Purpose of the Study

The purpose of my study is to explore the often-overlooked responsibilities that healthcare interpreters perform beyond language interpretation. While their primary role is to facilitate communication, I aim to examine how they contribute more broadly to patient care, provider workflow, and healthcare system efficiency. This research will investigate whether interpreters recognize and address patient needs that might go unnoticed by other healthcare providers, such as cultural mediation, patient advocacy, care coordination, and identifying barriers to care. Additionally, I will explore how they navigate these expanded roles while maintaining ethical boundaries and professional standards. By documenting these hidden

contributions, my goal is to provide a more comprehensive and accurate understanding of the integral role healthcare interpreters play within the medical system.

Researcher Positionality

As a Certified Healthcare Interpreter-Spanish (CHI-Spanish) and Commissioner for the Certification Commission for Healthcare Interpreters (CCHI), I participate in national discussions related to interpreter competencies, certification, training standards, and language access. From 2006-2026, I worked as an in-house healthcare interpreter at Mayo Clinic, where I observed the complex and evolving nature of interpreter practice within healthcare settings. Additionally, through my work as an educator and small business owner with Tica Interpreter Training and Translations, I have also had the opportunity to engage with interpreters working in a variety of institutional environments and specialties.

These experiences contributed to my interest in examining the roles healthcare interpreters perform within healthcare systems and how those contributions are perceived by interpreters, healthcare providers, and patients with limited English proficiency. At the same time, I recognize that my professional involvement in the field may influence my assumptions regarding the role and value of healthcare interpreters. To address this potential bias, I approached the study with a commitment to reflexivity and sought to allow participant perspectives and the data itself to guide the findings rather than confirm preconceived beliefs.

As a graduate student in the Master of Arts in Interpreting Studies program at Western Oregon University, I conducted this research to better understand how healthcare interpreters contribute to patient care beyond interpreting and whether aspects of their work remain underrecognized in research, policy, and practice. My goal is not to advocate for a predetermined

conclusion but to explore how interpreters' contributions are experienced and perceived by the stakeholders who interact with them.

Chapter 2: Literature Review

Introduction

Unlike judiciary interpreters—whose ethics emphasize strict non-intervention—healthcare interpreters navigate a different ethical landscape, one shaped by the principle of beneficence and the demands of culturally responsive care. According to the National Association of Judiciary Interpreters & Translators (n.d.), the *Code of Ethics and Professional Responsibilities* explicitly bars legal interpreters from engaging in advocacy or offering input. In contrast, the National Code of Ethics for Interpreters in Health Care (2004) permits thoughtfully framed intervention when patient safety or cultural misunderstandings are at risk. The difference is more than theoretical—it speaks to the reality interpreters face on the ground, especially in complex healthcare settings where neutrality is rarely a simple option. Such fundamental differences underscore the need for field-specific research and for a tailored certification approach that goes beyond language skills to include ethical reasoning in real-world contexts.

Yet this ethical flexibility creates a fundamental tension that remains underexplored in the literature. When patients with limited English proficiency encounter healthcare systems where interpreters may be their only cultural connection, the boundaries between professional neutrality and compassionate presence become increasingly complex. Interpreters often find themselves navigating competing ethical demands (Goler & Mack, 2024). The challenge lies in maintaining professional impartiality while responding to patients who seek comfort, cultural understanding, and emotional support during vulnerable medical encounters.

For decades, efforts to professionalize healthcare interpreting in the United States have been driven by both devastating patient outcomes and growing legal acknowledgment that

language access is a civil right. Youdelman (2013) traces this arc from early state-level initiatives to the founding of the Certification Commission for Healthcare Interpreters (CCHI), a vendor-neutral, stakeholder-informed organization built to meet national standards. Arocha and Joyce (2013) document the launch of the National Board of Certification for Medical Interpreters, pointing to patient safety, professional identity, and reimbursement policies as key forces shaping the credentialing movement. Both accounts stress that certification is more than a professional milestone—it's a safeguard, designed to distinguish trained interpreters from well-meaning but unqualified bilinguals.

Although certification standards and professional frameworks recognize the importance of ethics, professionalism, and cultural responsiveness, certification assessments primarily evaluate interpreters' linguistic and performance-based competencies through consecutive interpreting, simultaneous interpreting, sight translation, and medical terminology tasks (Certification Commission for Healthcare Interpreters [CCHI], 2024; National Council on Interpreting in Health Care [NCIHC], 2004). While existing scholarship has increasingly challenged traditional conduit models of interpreting, suggesting that interpreters are active participants in healthcare interactions rather than neutral language transmitters, comparatively less attention has been devoted to understanding how interpreters navigate ethical tensions, relationship-building, cultural nuance, and competing demands within real-world healthcare environments (Angelelli, 2004; Wadensjö, 1998).

Dean and Pollard (2011) argued that interpreters routinely encounter complex situational demands that require contextual judgment beyond the application of prescriptive ethical rules. Similarly, Plys et al. (2024) found that healthcare interpreters frequently engage in activities involving patient-provider liaison work, relationship-building, and case management, roles that

extend beyond traditional descriptions of linguistic mediation. Consequently, questions remain regarding how interpreters experience and resolve conflicts between professional expectations of neutrality and the realities of working closely with patients, providers, and healthcare systems.

The following analysis is organized into five interconnected themes, each addressing a key aspect of interpreter roles in healthcare. It begins by examining how professional interpreters influence health outcomes, highlighting the tangible benefits of trained language support in clinical care. It then explores the interpersonal and ethical skills interpreters draw on during high-stakes encounters—skills often undervalued but essential to effective communication. The third section turns to interpreter education, analyzing how training models prepare—or fail to prepare—interpreters for real-world demands. This is followed by a discussion of structural gaps in language access that limit the reach and consistency of interpreter services. The final section considers emerging scholarship on interpreter identity and ethics, challenging assumptions of neutrality and advocating for a more situated and responsive understanding of the profession. Together, these themes reveal not only what interpreters do in practice but illuminate the critical gap in understanding how interpreters themselves navigate the complex ethical terrain between professional boundaries and compassionate care. The review opens with research highlighting the measurable impact of professional interpreters on patient outcomes, including safety, satisfaction, and system-level efficiency.

Access and Outcomes

Much of the foundational literature on healthcare interpreting focuses on clinical outcomes for patients with limited English proficiency (LEP). Multiple studies link the use of trained interpreters to reduced medical errors, shorter hospital stays, and improved patient

satisfaction (Flores et al., 2012; Karliner et al., 2017; Lindholm et al., 2012). Joseph et al. (2018), in a systematic review comparing in-person, video, and phone interpretation, found that while patients often preferred in-person services, satisfaction levels remained high with any trained interpreter. These studies consistently affirm the value of professional language access but tend to zero in on the interpreter's performance during isolated encounters.

Kwan et al. (2023) take this further, synthesizing findings from 37 studies across Australia, the U.S., Canada, and Sweden. Their review confirms that professional interpreter services improve discharge comprehension, reduce readmission rates, lower costs, and lead to better pain management and shorter hospital stays. These benefits are not seen with ad hoc or untrained interpreters—reinforcing the argument that interpreters must be viewed as critical infrastructure, not just added support.

Yet, few studies explore how in-house interpreters, especially those embedded in hospital systems, contribute to longitudinal care: building trust, maintaining continuity, and helping patients navigate systems over time. Such hidden roles—often invisible in documentation but deeply felt in outcomes—are what this research seeks to name, validate, and bring to the forefront. What remains unexplored is how interpreters subjectively experience these relational responsibilities, particularly when patients seek comfort and cultural connection during vulnerable moments. While these studies underscore the value of interpreter presence, they rarely account for the relational, emotional, and ethical work interpreters perform during complex clinical encounters.

Development of Professional Standards

Since the late 1980s, professional organizations have developed ethical frameworks, standards of practice, and role guidance documents intended to define interpreter responsibilities and support ethical decision-making in healthcare settings. Among the earliest of these efforts was a medical interpreter code of ethics established in 1987 and later revised in 2006 (International Medical Interpreters Association [IMIA], 2008). In 1995, the International Medical Interpreters Association and the Education Development Center developed the first Standards of Practice for spoken-language medical interpreters in the United States (IMIA & EDC, 1995). These standards organized interpreter responsibilities around three core areas: interpretation, cultural interface, and ethical behavior. Subsequent efforts included NCIHC's examination of interpreter role conceptualizations (Avery, 2001), the development of role-based standards by the California Healthcare Interpreting Association (CHIA, 2002/2017), and the publication of national ethical and practice standards by the National Council on Interpreting in Health Care (NCIHC, 2004, 2005). Together, these frameworks established many of the principles that continue to guide healthcare interpreting practice today, including accuracy, confidentiality, impartiality, cultural awareness, professionalism, advocacy, and professional boundaries.

The development of ethical guidance has continued as the profession has evolved. CHIA's standards articulated multiple interpreter roles, including message converter, message clarifier, cultural clarifier, and patient advocate (CHIA, 2002/2017), while NCIHC later revisited questions surrounding advocacy and interpreter intervention in healthcare encounters (NCIHC, 2021). Outside of healthcare interpreting, signed language interpreters have operated under formal ethical guidance since the 1960s. The Registry of Interpreters for the Deaf (RID) adopted its first Code of Ethics in 1965, with subsequent revisions culminating in the RID-NAD Code of

Professional Conduct (RID & NAD, 2005). Although these frameworks are not specific to healthcare interpreting, they demonstrate that questions regarding interpreter ethics, neutrality, professional conduct, and role boundaries have been debated across interpreting professions for decades. Collectively, these frameworks reflect ongoing efforts to define interpreter responsibilities and establish ethical guidance for increasingly complex practice environments.

Evolution of Interpreter Role Conceptualizations

The role of the interpreter has been the subject of ongoing debate within interpreting studies. Early conceptualizations largely reflected a conduit model, portraying interpreters as neutral and impartial transmitters of information whose primary responsibility was the accurate transfer of messages between speakers (Dysart-Gale, 2005). Over time, however, scholars increasingly questioned whether interpreters function as passive language conduits in practice. Research across healthcare, community, and sign language interpreting contexts demonstrated that interpreters frequently encounter situations involving cultural differences, power imbalances, misunderstandings, and participant needs that cannot be addressed through linguistic transfer alone (Witter-Merithew, 1999; Avery, 2001). As a result, role conceptualizations expanded to include functions such as clarification, facilitation, cultural mediation, and advocacy, which were subsequently reflected in professional frameworks developed by organizations such as CHIA (2002/2017).

More recent scholarship has moved beyond discrete role categories altogether and toward understanding interpreter behavior as fluid, situational, and responsive to interactional needs. Researchers have argued that interpreters continually negotiate their participation based on institutional expectations, participant goals, and contextual demands rather than operating within

a single prescribed role (Angelelli, 2004, 2019; Major & Napier, 2019). Álvaro Aranda (2020) further demonstrated that interpreters often engage in rapport-building, emotional support, patient education, and other visible forms of participation during "in-between" moments that occur before, after, and between interpreted encounters. Similarly, Mikkelson's (2015) review of Llewellyn-Jones and Lee's role-space framework describes interpreter behavior as dynamic and context dependent rather than fixed. Together, these developments reflect a broader shift within interpreting studies away from viewing interpreters as passive language conduits and toward recognizing them as active participants who continuously navigate linguistic, cultural, relational, and institutional complexities.

Despite decades of professional standards and evolving role frameworks, disagreement remains regarding the appropriate boundaries of interpreter participation in healthcare encounters. While ethical codes emphasize accuracy, impartiality, and professional boundaries, researchers have repeatedly documented interpreters engaging in activities such as cultural mediation, patient advocacy, emotional support, and communication management (Angelelli, 2004; Davidson, 2000; Hsieh, 2008; Álvaro Aranda, 2020). This tension between prescribed professional expectations and the realities of clinical practice has become one of the central debates in healthcare interpreting scholarship (Hsieh et al., 2010). As interpreters navigate increasingly complex interactions, questions remain regarding how ethical decisions are made, when intervention is appropriate, and how interpreters balance professional neutrality with patient needs.

Beyond Words: Skills & Ethics

There's growing consensus in the field that language skills alone do not make someone a great healthcare interpreter. Research from the Certification Commission for Healthcare Interpreters (CCHI, 2016; 2022) and Crane (2022) shows that emotional intelligence, flexibility, and cultural responsiveness are essential for high-quality interpreting. And yet, these so-called "soft skills" remain undervalued in many institutional job descriptions—despite their direct impact on patient care.

Herring (2018) and Dean (2014) go further, framing interpreters not just as neutral relays but as real-time decision-makers navigating messy, high-stakes conversations. They point out that interpreters are constantly managing power dynamics, weighing risks, and adjusting their positioning to protect both patient safety and communication flow. Growing awareness of this complexity has prompted further inquiry into how interpreters develop and demonstrate ethical reasoning in real time—and whether current training models support that development.

These findings raise important questions about how interpreter education prepares practitioners to handle ethical complexity in clinical contexts. Both Dean (2021) and Sielen (2023) emphasize that effective interpreting requires far more than the ability to render accurate linguistic equivalents. They argue that interpreters must engage in contextually situated ethical reasoning, yet each approaches this issue from a different angle. Dean (2021) focuses on structured reflection and tacit knowledge, proposing that reflective practice is essential to developing what Schön (1983) calls "knowledge-in-action"—the ability to consciously understand and articulate the reasoning behind one's professional decisions. Dean's (2021) assessment tools, grounded in medical education and interpreter observation, aim to operationalize context as a measurable and teachable component of interpreter competence.

Sielen's (2023) work similarly explores interpreters' capacity for ethical decision-making, but through the lens of moral development theory. Drawing on the neo-Kohlbergian model and the four-component model of moral behavior, she distinguishes between bedrock schemas, intermediate concepts, and surface-level rules. Her findings suggest that interpreters with minimal training may still develop strong ethical reasoning skills, but they often struggle to verbalize their thought processes due to limited exposure to professional language and norms.

Several scholars have questioned whether language access alone is sufficient to address the needs of patients with limited English proficiency. Crezee and Roat (2019), for example, compared healthcare interpreters with bilingual patient navigators and found that navigators were often able to build trust, identify barriers to care, provide health literacy support, and assist patients in navigating complex healthcare systems. The authors argued that while interpreters facilitate communication within individual encounters, patients with limited health literacy or limited familiarity with healthcare systems may require additional support that extends beyond language access alone.

Together, these studies highlight a crucial gap in interpreter education: even when interpreters make ethically sound decisions, they may lack the tools to explain or justify their actions. This has implications not only for training and certification, but also for professional recognition, as the ability to articulate ethical reasoning is often mistaken for having it. Critically, neither study examines how interpreters experience the emotional labor of making these ethical decisions, particularly when patients from their own cultural communities seek support that challenges traditional neutrality boundaries. Both authors call for more intentional ethics education, rooted in real-world case analysis, to bridge the divide between what interpreters know and what they can explain.

In other words, interpreters bring far more to the table than terminology and grammar. They also bring judgment, presence, and relational insight. If we want certification to truly reflect the demands of the job, we must start valuing the full range of skills interpreters possess, particularly the ethical reasoning they carry out spontaneously in unpredictable situations. However, while scholars like Dean (2021) and Sielen (2023) acknowledge interpreters' ethical decision-making capabilities, neither directly examines how interpreters themselves experience and resolve the tension between prescribed neutrality and compassionate presence—particularly during emotionally charged encounters where patients seek cultural connection and support. Yet, even as the profession acknowledges these essential competencies, interpreter education often struggles to keep pace with the real-life complexity of medical encounters.

Training for Reality

If interpreters are expected to manage complex, high-stakes interactions, the way we train them needs to reflect that reality. Sultanić (2018) offers a comprehensive look at interpreter readiness and the limitations of traditional training approaches. Drawing on situated learning theory, she finds that most interpreter education—whether academic or para-academic—is still largely decontextualized. Students may learn role boundaries and terminology, but they rarely get hands-on exposure to real hospital environments. HIPAA restrictions, institutional silos, and the tendency to treat interpreters as outsiders rather than care team members all contribute to this disconnect.

Nguyen et al. (2024) take a different approach. In their study, interpreters were embedded directly into the pre-clerkship training for medical and physician assistant students. Rather than simply participating, interpreters became co-educators—offering live feedback, modeling best

practices, and helping students strengthen their cross-cultural communication skills. The result? Medical students felt more confident, and interpreters reported being recognized as valued contributors. It's a glimpse of what interpreter integration can look like when institutional culture supports it.

Dean (2021) deepens this conversation by introducing a structured reflection model based on Donald Schön's (1983) theory of reflection-in-action. Her 15-point tool helps assess how interpreters respond to context in real time, including environmental factors, power dynamics, paralinguistics, and interpersonal cues. It also evaluates how interpreters reason through ethical challenges, manage rapport, and position themselves within clinical encounters. The takeaway is clear: contextual literacy is not just an instinct—it's a teachable, measurable skill.

Together, these studies push back against the idea that interpreting is simply about language. They show that interpreters are educators, collaborators, and reflective practitioners who constantly adapt to the needs of the moment. Building these competencies into training—and eventually into certification—could make a major difference in preparing interpreters not just to pass a test, but to thrive in real-world practice. However, none of these training models directly address how to prepare interpreters for the emotional complexity of serving patients who may view them as cultural anchors in monolingual healthcare settings. Still, the effectiveness of interpreter training is only part of the equation. System-level barriers continue to undermine language access and the integration of interpreters into healthcare teams.

Structural Gaps in Language Access

Patients with limited English proficiency (LEP) face disproportionate barriers to healthcare access and suffer poorer outcomes than their English-speaking peers (Chipman et al.,

2024; Espinoza & Derrington, 2021; Giglio et al., 2022). Espinoza and Derrington (2021) argue that language-based health disparities represent both distributive injustice—limited access to essential care—and relational injustice, in which patients are devalued and "othered" due to their linguistic background. The authors frame language as a *morally irrelevant trait* and emphasize clinicians' and institutions' ethical and legal responsibilities to ensure equitable care.

Espinoza and Derrington (2021) describe how interpreter shortages, systemic underfunding, and lack of clinician training result in inconsistent interpreter use—even when regulations mandate it. In their case study, a 13-year-old patient experienced a ruptured appendix and septic shock after multiple emergency department visits where interpreter services were inadequate. When systems fail in this way, they may intensify the ethical burden on interpreters, who become patients' primary—and sometimes only—source of cultural understanding and support. The authors go on to showcase a successful institutional intervention that reduced pediatric intensive care unit mortality for Latinx children by addressing language access, staffing, outreach, and cultural responsiveness at multiple levels.

Taira and Orue (2019) further illustrate these system-level failures in a study of language assistance use in a public emergency department. During a 48-hour review period, 43% of patients requested language services, yet 84.5% of those requests went unmet, despite the hospital having 24/7 video and phone interpreting and a bilingual provider program. The issue was not access to tools, but lack of documentation, tech integration, and workflow clarity.

Alarcon et al. (2024) reinforce this picture by documenting how even in a safety-net academic medical center where 28.4% of patients had LEP, proficiency testing for bilingual clinicians was rarely used. Providers often relied on self-assessment rather than validated measures, increasing the risk of communication errors. Despite having access to interpreter

services and a credentialing process for bilingual staff, the study found little formal integration of these systems into care workflows—mirroring the invisibility and undervaluation of interpreter services as institutional infrastructure.

Kwan et al. (2023) further emphasize that despite the documented benefits of interpreter services, systemic underuse and provider inconsistency remain common barriers. Their findings highlight that language access must go beyond availability—it requires institutional integration, workforce development, and policy-driven accountability. These systemic gaps align with this study's focus on the structural undervaluing of interpreters and the need for ethical, professional recognition.

Meyer et al. (2024) provide a broader systemic lens by introducing the Trust in Multidimensional Healthcare Systems Scale (TIMHSS). Their work identifies institutional trust as a measurable and multidimensional construct, particularly relevant to patients from equity-deserving groups. Although the article does not focus directly on interpreters, its findings bolster the case that interpreters influence key institutional trust indicators—especially through sustained presence, cultural mediation, and patient-centered interaction.

Castro et al. (2022) offer critical empirical support by examining trauma outcomes among 13,000+ patients at a Level 1 trauma center. Their findings reveal that LEP patients—particularly those speaking languages other than Spanish or Chinese—experienced significantly higher rates of morbidity, longer hospital stays, and increased mortality, even after adjusting for injury severity. These disparities suggest not just communication gaps, but system-level breakdowns in language-concordant care.

The research reveals life-and-death consequences of language access failures and support this study's call to make interpreters central to institutional quality and equity frameworks. These system-level failures not only limit language access but also intensify the ethical dilemmas interpreters face when patients turn to them as cultural anchors in an otherwise alienating healthcare environment. To address the full scope of interpreter responsibility, recent research urges a reevaluation of core ethical principles, particularly the expectation of neutrality in complex, real-world encounters.

Reframing Interpreter Ethics: Identity, Agency, and Context

Recent scholarship challenges the long-held ideal of interpreter neutrality, suggesting it may obscure the complex realities interpreters face—particularly those from marginalized communities. Rusho (2023), in her ethnographic work with First Nations legal interpreters in Australia, argues that neutrality and invisibility are not only unrealistic but potentially unethical in contexts shaped by cultural erasure and kinship responsibilities. She advocates for a shift toward impartiality grounded in cultural and situational awareness, highlighting the interpreter's role as an embedded actor rather than a detached conduit.

Building on this reconceptualization, Yuan (2022) introduces the Symbolic Interactionist Model of Interpreter's Identity Management (SIMIIM), which illustrates how interpreters navigate conflicts between their professional roles and personal moral values. Interpreters often manage layered identities in real time, reconciling institutional expectations with ethical instincts rooted in personal and community experience. This emotional labor and identity negotiation further complicate the myth of neutrality.

Similarly, Sielen (2023) examines how ethics is taught—and practiced—within healthcare and community interpreting. Her mixed-methods study reveals that many interpreters lack formal ethics training and instead rely on simplified role metaphors and rules-based reasoning. Yet, her use of tools like the Defining Issues Test (DIT, later updated to DIT2) and think-aloud interviews demonstrates that interpreters do engage in contextual ethical reasoning; they simply lack the language and training to articulate it. Her findings highlight a gap in current certification systems, which often emphasize procedural compliance over contextual moral judgment, but do not capture how interpreters navigate the emotional terrain when patients seek comfort from someone who shares their cultural background.

Collectively, these sources (Rusho 2023; Sielen 2023; Yuan 2022) reinforce the need to reframe interpreter ethics as context-dependent, emotionally nuanced, and culturally situated. Rather than viewing interpreters as neutral agents, this research aligns with a growing call to recognize interpreter agency, invest in deeper ethics training, and reevaluate credentialing systems to reflect the real-world demands of the profession.

Across outcome research (Flores et al., 2012; Joseph et al. 2018; Karliner et al., 2017; Kwan et al., 2023; Lindholm et al., 2012), ethics scholarship (Sielen, 2023; Dean, 2021), and critical theory (Rusho, 2023; Yuan, 2022), there's growing recognition that interpreters navigate multifaceted roles requiring contextual judgment. Yet, a critical gap remains; while scholars acknowledge this complexity theoretically, none have systematically examined how interpreters themselves experience and manage the specific tension between neutrality mandates and the human impulse to provide comfort to vulnerable patients from their own cultural communities.

This study addresses that gap by directly investigating interpreters' lived experiences of ethical decision-making, particularly in moments when patients seek emotional support and

cultural connection. By triangulating interpreter, provider, and patient perspectives on these encounters, this research will illuminate not just what interpreters do, but how they justify and navigate these complex ethical territories in real-time. Each of these strands—clinical outcomes, interpersonal skill, training, structural barriers, and ethical reframing—converges around a shared insight: interpreters are doing much more than language conversion, and current systems have yet to fully catch up.

Theoretical Framework

This study is grounded in Muted Group Theory (MGT), which provides a lens for understanding how power shapes communication, whose perspectives are recognized, and how meaning is constructed within institutional settings. MGT posits that dominant groups control language, discourse, and the systems through which knowledge is validated, while non-dominant groups must adapt their experiences into those structures to be heard (Ardener, 2005; Kramarae, 2005). Originating as a result of incongruent treatment of men's and women's discourse in the field of archaeology, it was later extrapolated by Ardener (2005) that the theory had broader applications.

Kramarae (2005) succinctly sums up MGT in the following passage:

> Muted group theory suggests that people attached or assigned to subordinate groups may have a lot to say, but they tend to have relatively little power to say it without getting into a lot of trouble. Their speech is disrespected by those in the dominant positions; their knowledge is not considered sufficient for public decision-making or policy making processes of that culture; their experiences are interpreted for them by others; and they are encouraged to see themselves as represented in the dominant

> discourse. The theory further suggests that an important way that a group maintains its dominance is by stifling and belittling the speech and ideas of those they label as outside the privileged circle (Kramarae, 2005, p. 55).

Within healthcare in the United States, this power dynamic is highly visible in verbal and written communication. Healthcare providers and institutions function as the dominant group, shaping what counts as relevant information, how communication occurs, and how patient understanding is assessed. Limited English proficient (LEP) patients, by contrast, and to a lesser degree, medical interpreters, often occupy a structurally muted position. Their experiences, concerns, and cultural frameworks may not align with dominant medical discourse, requiring them to communicate through a foreign system that puts them at a disadvantage. For instance, many LEP patients rely on interpreters to express their realities within a system that was not designed for them, while medial interpreters are often not recognized as communication and cultural authorities who are part of the healthcare team unless intentional efforts are made to ask for their expertise (Nguyen et al., 2024; Syawal et al., 2024).

Muted Group Theory is particularly useful for this study because it shifts the focus away from communication as a neutral exchange and instead frames it as a power-mediated process. Communication breakdowns in healthcare are not simply linguistic failures but reflect deeper structural imbalances in whose voice carries authority and whose knowledge is recognized. As described in MGT, muting does not mean absence of voice, but rather a lack of recognition, legitimacy, and access to dominant forms of expression (Kramarae, 2005; Barkman, 2018).

In this context, healthcare interpreters occupy a unique and complex position. They are not fully part of the dominant group, yet they are required to operate within its structures. At the same time, they maintain linguistic and cultural alignment with patients, who may be structurally

muted. This places interpreters in a dual role: they must transfer not only language but also meaning across unequal systems of power. As MGT suggests, this type of work requires individuals to become "bilingual" in more than language alone, navigating multiple systems of meaning while adapting patient experiences into forms that are recognized within dominant discourse (Barkman, 2018).

This framework helps explain why interpreters frequently engage in activities outside of strict language interpretation. When patients' experiences do not fit neatly within biomedical communication structures, interpreters may intervene to clarify meaning, highlight cultural context, or support patient understanding. These actions are not deviations from their role, but responses to structural gaps in communication. In many cases, interpreters are working to reduce the effects of muting by ensuring that patient perspectives are not lost, dismissed, or misunderstood (Allison & Hibbler, 2004).

At the same time, MGT also highlights why these contributions often go unrecognized. Because dominant systems define what counts as legitimate communication, interpreter actions that fall outside of strict message transfer may be viewed as unnecessary, inappropriate, or invisible (Hsieh & Kramer, 2012). This aligns with the gap identified in this study: interpreters are performing critical functions that support patient care and system navigation, yet these functions are rarely acknowledged in policy, training, or research. Existing scholarship has documented interpreter contributions to care coordination, trust building, patient navigation, and other activities beyond linguistic mediation (Latif et al., 2022; Plys et al., 2024), while broader healthcare systems often continue to prioritize productivity and utilization metrics that may fail to capture these relational and communication-based contributions (Hempel et al., 2021; Teisberg et al., 2020).

Muted Group Theory also provides a way to understand the ethical tension interpreters experience. Professional guidelines emphasize neutrality and role boundaries, yet real-world encounters often require interpreters to respond to situations where patients are confused, distressed, or unable to advocate for themselves. From an MGT perspective, these moments represent points where structural muting is most visible. Interpreters are forced to navigate between maintaining professional expectations and addressing the communication barriers created by unequal power dynamics. As Pyle (2025) suggests, individuals operating within constrained systems may adapt, self-silence, or find alternative ways to act when direct expression is limited.

This study uses Muted Group Theory to examine how interpreters operate within these constraints and how their actions may function as a form of practical resistance to muting. By exploring perspectives from interpreters, healthcare providers, and LEP patients, this research seeks to identify where communication gaps occur, how interpreters respond to them, and how their contributions are perceived across different stakeholder groups.

Ultimately, this framework supports the central argument of this study: healthcare interpreters are not simply neutral conduits of language, but active participants in negotiating meaning within a system shaped by power. Their expanded roles emerge as necessary responses to structural limitations in how healthcare communication is organized and understood.

To explore these questions in practice, the following chapter outlines the research design and methods used in this study.

Chapter 3: Methodology

I used a mixed-methods approach that combines quantitative and qualitative survey data to explore the roles that medical interpreters perform beyond linguistic mediation. By gathering perspectives from interpreters, healthcare providers, and Limited English Proficient (LEP) Spanish-speaking patients, I aimed to understand how different stakeholders experience and view interpreters' contributions to healthcare delivery.

Research Design

The study used three separate questionnaires to collect both quantitative and qualitative data simultaneously. This approach allowed me to compare different stakeholder perspectives on interpreter roles. It also helped develop a more complete understanding of what interpreters do in practice versus what their job descriptions say they should do.

Survey Development

Because no existing instrument was identified that directly examined healthcare interpreters' activities beyond linguistic mediation, the survey instruments for this study were developed by the researcher. Question development was informed by the literature review, nearly twenty years of professional experience as a healthcare interpreter, experience training healthcare interpreters from multiple language backgrounds, and ongoing professional discussions within the interpreting field at a regional and national level.

Survey items were designed to explore areas repeatedly identified in both the literature and professional practice, including cultural mediation, emotional support, patient advocacy, care

coordination, ethical decision-making, professional boundaries, interpreter integration within healthcare teams, and differences across interpreting modalities. Multiple-choice response options were developed to reflect common situations, ethical tensions, and role expectations observed in healthcare settings and discussed by interpreters and healthcare professionals.

The survey development process was iterative. Draft instruments were reviewed by the research advisor, Dr. Elisa Maroney, and committee member Professor Elizabeth Jean-Baptiste to evaluate question clarity, relevance, and alignment with the study's research questions. The medical interpreter survey was additionally reviewed by practicing healthcare interpreters who provided feedback on wording, content coverage, and usability. Revisions were incorporated prior to data collection. While the provider and patient surveys were reviewed by faculty advisors, they were not formally pilot tested.

This approach was intended to establish content validity by ensuring that survey questions reflected both issues identified in the literature and challenges commonly encountered in real-world healthcare interpreting practice. To further promote consistency in participant responses, operational definitions of key concepts were incorporated into the survey instruments.

Operational Definitions

Because concepts such as emotional support, advocacy, cultural mediation, professional boundaries, and tasks beyond interpreting may be understood differently by healthcare interpreters, healthcare providers, and patients, operational definitions were provided within each survey instrument. These definitions were intended to establish a common frame of reference for participants when responding to survey questions and to reduce variation resulting from differing interpretations of key terminology. While some definitions varied across stakeholder groups to

reflect differences in participant background and experience, all were designed to support the study's examination of interpreter activities beyond linguistic mediation.

Table 1

Operational Definitions Used in Survey Instruments

Term	Definition
Advocacy	When interpreters speak out to protect patients from serious harm or mistreatment.
Cultural Awareness	The expectation that interpreters are familiar with their LEP patient population's culture and alert healthcare providers to possible cultural misunderstandings.
Cultural Mediation	When medical interpreters intervene to alert healthcare providers to possible cultural misunderstandings.
Cultural Connection	Shared understanding based on similar cultural or linguistic backgrounds.
Culture	A participant's country of origin, traditions, and customs.
Emotional Support	Providing comfort, reassurance, or understanding in addition to interpreting medical information.
LEP Patient	A patient with Limited English Proficiency who requires interpreter services.
Professional Interpreter	A trained individual who facilitates communication between patients and healthcare providers by accurately conveying what each person says.
Professional Boundaries	Formal guidelines that define an interpreter's role and responsibilities, ensuring that interpreters perform only duties appropriate to the interpreting role and do not assume responsibilities outside that scope.
Tasks Beyond Interpreting	Any actions taken by interpreters during an encounter that extend beyond the accurate and impartial transfer of spoken or signed messages, including advocacy, decision-making, administrative or clinical tasks, providing opinions or advice, or responding directly to the emotional needs of patients, family members, or providers.
Other	Any additional concepts, activities, or situations not covered by the above definitions.

Of these definitions, "tasks beyond interpreting" served as the primary operationalization of the central phenomenon examined in this study. Questions throughout the survey instruments

were designed to explore participant perceptions of interpreter activities that extended beyond traditional linguistic mediation as defined above.

Participants

I recruited three distinct participant groups:

Healthcare Interpreters: Currently practicing medical interpreters working in healthcare settings. I did not limit this by employment type (staff, contract, or freelance), certification status, or years of experience since I aimed to capture the full range of interpreter experiences. Participants needed to be 18 years or older and actively providing interpretation services.

Healthcare Providers: Healthcare professionals who regularly work with medical interpreters and LEP patients, including physicians, nurses, nurse practitioners, physician assistants, social workers, and administrative staff. Participants needed to be 18 years or older and currently working in healthcare settings where they collaborate with interpreters.

LEP Patients: Individuals 18 years or older who received medical interpreter services in healthcare settings. This study focused specifically on limited English proficient (LEP) Spanish-speaking patients. Participants received professional interpretation services in healthcare settings.

Data Collection

Data was collected through three distinct online questionnaires, each tailored to the specific participant group. Draft versions of these questionnaires were developed and refined prior to IRB submission and data collection:

Medical Interpreter Questionnaire

The medical interpreter comprehensive survey (approximately 20-30 minutes) explored interpreters' experiences with roles beyond linguistic mediation (see Appendix A). The patient consent form and survey were translated into Spanish by a professional Spanish-to-English translator, Kimberly Martinez. The translated materials were subsequently reviewed by the researcher, a nationally certified healthcare interpreter (CHI-Spanish), to ensure the Spanish-language version accurately reflected the meaning and intent of the original English instrument. Formal back-translation was not conducted.

The questionnaire covered background information like certification and training, how interpreters decided when to intervene beyond just interpreting, their experiences providing emotional support and cultural connection, critical decision points where they faced ethical conflicts, how well they were integrated into healthcare teams, and their confidence with professional standards. I used a mix of multiple-choice questions, rating scales, and open-ended responses to capture both measurable patterns and the nuanced realities of their work.

Healthcare Provider Questionnaire

This survey (approximately 20-30 minutes) examined providers' observations and perspectives on interpreter contributions (see Appendix A). I strove to understand what providers observed interpreters doing, whether they recognized interpreter contributions beyond language services, how they viewed interpreter interventions, and what they thought about expanded interpreter roles. The survey also explored their training and knowledge about interpreter roles and what support they needed to work more effectively with interpreters.

LEP Patient Questionnaire

This survey (approximately 20-30 minutes) captured patient experiences with interpreter services beyond language interpretation (see Appendix A). The questionnaire was available in Spanish to accommodate Spanish-speaking participants. I was particularly interested in whether patients noticed when interpreters assisted them beyond meaning transfer tasks, how they felt about receiving emotional support or cultural connection from interpreters, and what their expectations were for interpreter services.

All questionnaires were available online through a secure survey platform for four weeks following dissemination. The surveys included both closed-ended questions for statistical analysis and open-ended questions to capture specific examples and detailed experiences.

Data Analysis

Quantitative Analysis

I analyzed survey responses using descriptive statistics, such as frequency counts, percentages, and averages to identify patterns in how often interpreters performed non-linguistic tasks, how providers recognized interpreter contributions, and how satisfied patients were with expanded interpreter roles. I also analyzed relationships between variables like interpreter certification status, years of experience, work setting, and frequency of expanded role activities.

Qualitative Analysis

Open-ended survey responses were analyzed using an inductive thematic analysis approach (Braun & Clarke, 2006; Braun & Clarke, 2019; Naeem et al., 2023). This approach was selected to identify recurring patterns, concepts, and themes emerging directly from participant responses rather than applying predetermined categories. Responses were reviewed multiple

times to promote familiarity with the data and to identify areas of similarity, variation, and recurring ideas across participants.

During the initial stages of analysis, responses were manually color coded to facilitate the identification of meaningful concepts and emerging patterns. Consistent with inductive thematic analysis procedures, descriptive codes were developed directly from the data and were refined through repeated engagement with participant responses (Braun & Clarke, 2006; Naeem et al., 2023). Coding and theme development were conducted using Microsoft Word and Excel rather than specialized qualitative analysis software.

Following the initial coding process, related codes were grouped into broader thematic categories. Themes were reviewed and refined through an iterative process that involved moving repeatedly between the original responses, coded segments, and developing themes to ensure that thematic interpretations remained grounded in the data (Braun & Clarke, 2019). This process allowed for the identification of patterned meanings that addressed the study's research questions while preserving the complexity of participant perspectives.

After themes were established, I conducted an additional review of the data to identify representative quotations that illustrated both common experiences and diverse viewpoints within each theme. Quotations were selected to provide evidence of the themes identified and to preserve participants' voices within the presentation of the findings. Through repeated review, refinement, and interpretation of the data, a coherent thematic framework was developed to capture participants' perceptions of healthcare interpreters' roles beyond linguistic message transfer skills.

Bringing It All Together

The mixed-methods approach allowed me to compare how interpreters, healthcare providers, and patients viewed interpreter roles differently. I expected to find some areas where all groups agreed and others where perspectives diverged significantly. Based on my professional experience and the literature reviewed, I anticipated that interpreters would report frequently engaging in activities beyond language interpretation, such as providing emotional support, cultural mediation, and assisting patients in navigating healthcare systems, while healthcare providers would be less aware of how often these roles occurred in practice. I also expected that Spanish-speaking patients who worked with trained interpreters would recognize and value these broader contributions. This comparison was designed to explore whether gaps existed between what different stakeholders expected from interpreters and what occurred in practice.

Recruitment and Distribution

I recruited participants through professional networks, healthcare institutions, and community organizations. The questionnaires were distributed electronically through professional associations, healthcare systems, and interpreter service organizations to reach participants across different geographic regions and healthcare settings.

Ethical Considerations

Institutional Review Board (IRB) approval was obtained from Western Oregon University prior to data collection. All participants were consented through online consent forms before accessing the questionnaires (see Appendix B). Data was collected anonymously through a secure web-based survey platform, with no collection of identifying information such as

names, email addresses, or IP addresses. All responses remained confidential and anonymous, encouraging honest responses about potentially sensitive professional situations.

Chapter 4: Results

In total, 193 participants completed the surveys. Of these participants, 159 responded to the medical interpreter survey, 19 the healthcare provider survey, and 15 the Spanish-speaking LEP patient survey.

Medical Interpreter Findings

This section presents the findings from the medical interpreter survey portion of the study. The quantitative results provide insight into interpreters' professional backgrounds, clinical practice environments, ethical decision-making processes, and perceptions of their roles within healthcare settings. Particular attention is given to interpreters' involvement in activities that extend beyond direct language interpretation, including emotional support, cultural mediation, patient advocacy, healthcare navigation, and collaboration with healthcare teams.

The section begins with descriptive quantitative findings related to participant demographics, professional qualifications, clinical practice characteristics, and perceptions of interpreter roles and responsibilities. Figures and tables are included to illustrate key patterns and areas of consensus among respondents. The quantitative findings are followed by a qualitative analysis of interpreters' open-ended responses, which provides additional context regarding professional boundaries, ethical tensions, patient support, cultural mediation, healthcare team integration, and the broader contributions interpreters perceive themselves as making to patient care.

Quantitative Findings

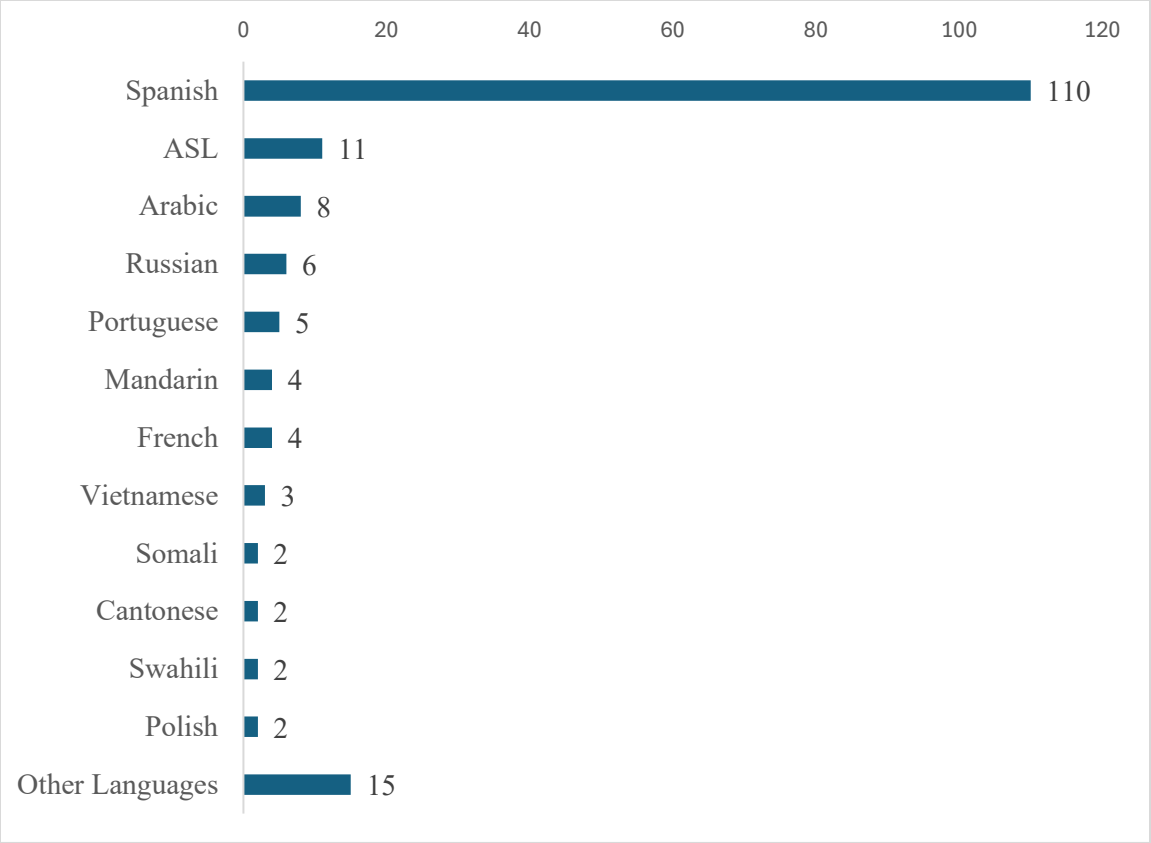
Participant Demographics and Professional Background

Medical interpreter respondents were primarily female (78%), with representation across all adult age ranges: 18-29 (12.6%), 30-39 (22.6%), 40-49 (26.4%), 50-59 (23.9%), 60 or older (14.5%). This distribution is consistent with broader workforce data indicating that the interpreter and translator profession in the United States is predominantly female (Data USA, 2024)

Respondents also represented a wide range of primary working languages other than English (see Figure 1). Spanish was the most frequently reported working language, though the sample also reflected linguistic diversity across several additional languages, including ASL, Arabic, Russian, Portuguese, Mandarin, French, Vietnamese, Somali, Swahili, Cantonese, and Polish. Several participants reported working in more than one language; therefore, totals exceed the number of respondents.

Figure 1

Primary Working Languages Reported by Medical Interpreter Participants



Note. Participants were permitted to select more than one working language; therefore, totals exceed the number of respondents.

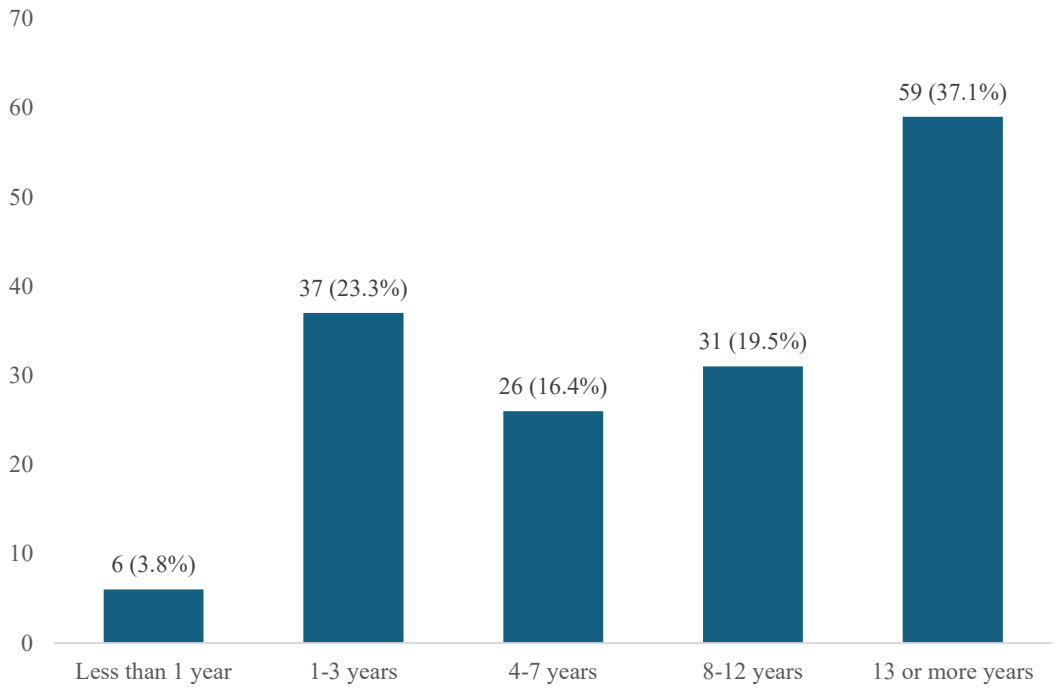
Participants represented a variety of employment arrangements within the healthcare interpreting field. The largest groups consisted of healthcare institution employees (n = 67) and independent contractors/freelancers (n = 57), followed by language services provider (LSP) employees (n = 27). Language services provider (LSP) employees were interpreters employed by companies that contract language services to healthcare organizations rather than being directly employed by hospitals or healthcare systems. Smaller numbers of participants identified as dual-role interpreters (n = 5), volunteers (n = 2), or educators (n = 1). The dual-role category included individuals who interpreted while also serving in another professional capacity, such as nursing

or nonprofit work. Minimal overlap was observed across categories, with only one participant reporting both freelance and educator roles.

Medical interpreter respondents represented a wide range of professional experience levels. The largest group reported 13 or more years of experience (37.1%, n = 59), followed by 1–3 years (23.3%, n = 37), 8–12 years (19.5%, n = 31), and 4–7 years (16.4%, n = 26). A smaller number of participants reported less than 1 year of experience (3.8%, n = 6). Overall, the sample reflected a relatively experienced interpreter workforce, with more than one-third of respondents reporting 13 or more years in the field (see Figure 2).

Figure 2

Years of Experience Among Medical Interpreter Respondents



Clinical Practice Characteristics

Participants reported working across a variety of clinical settings. Hospitals (n = 145) and outpatient clinics (n = 136) were the most frequently reported settings. Smaller numbers reported working in home visit settings (n = 11) and other environments such as schools, legal settings, and community centers (n = 6). Because many interpreters reported working across multiple clinical settings, frequencies exceeded the total number of participants.

Respondents reported working across a variety of interpreting modalities, including in-person interpreting, video remote interpreting (VRI), and over-the-phone interpreting (OPI). While in-person interpreting was the most reported modality overall, many respondents reported working across multiple service delivery formats rather than a single modality. Forty-six respondents reported working exclusively in-person, while 43 respondents reported working across all three modalities. Smaller numbers of respondents reported working exclusively in VRI (n = 3) or OPI (n = 5). These findings suggest that many interpreters in the sample worked within flexible and multimodal service delivery environments.

Participants were asked not only which interpreting modalities they worked in, but also the approximate percentage of time spent working in each modality. To better understand workload distribution, participants were categorized according to their dominant modality, defined as the modality in which they reported spending the greatest percentage of their interpreting time. Table 1 presents interpreting service combinations alongside dominant modality patterns.

Table 1

Interpreting Service Combinations and Dominant Modality Among Respondents

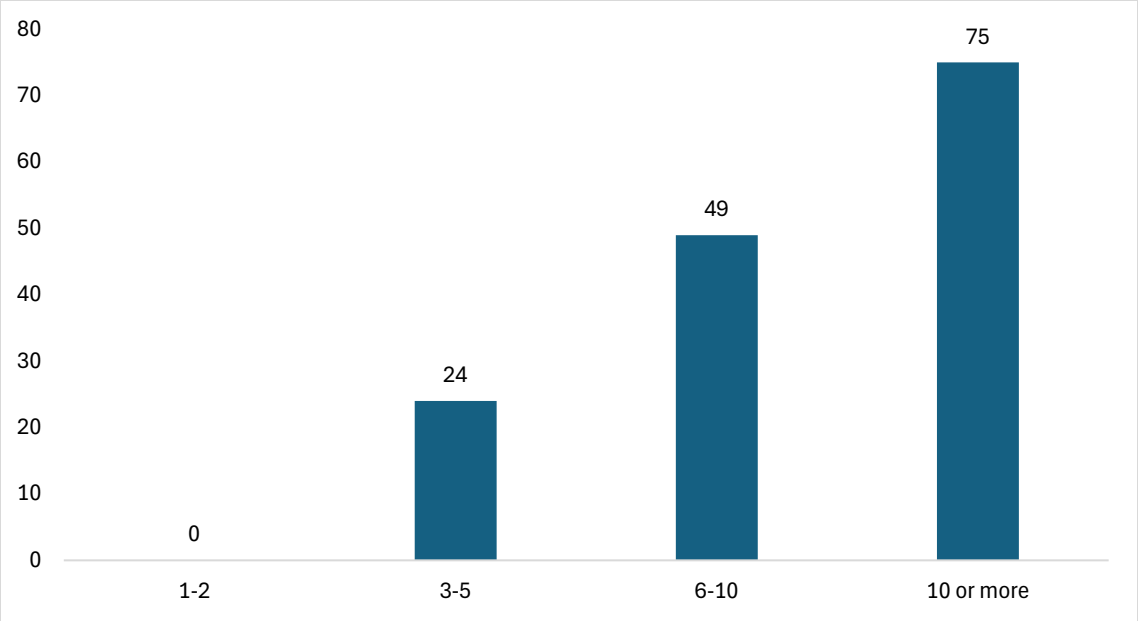
Interpreting Modalities and Combinations	Primarily In-person	Primarily OPI	Primarily VRI	Grand Total
In-person only	44	1	1	46
All three modalities	32	3	8	43
In-person + VRI	21	0	5	26
VRI + OPI	0	15	9	24
In-person + OPI	11	1	0	12
OPI only	1	4	0	5
VRI only	0	0	3	3
Grand Total	**109**	**24**	**26**	**159**

As shown in Table 1, many interpreters worked across multiple modalities while still maintaining a primary service delivery format. The largest group worked exclusively in-person and identified in-person interpreting as their dominant modality (n = 44). In addition, 43 interpreters reported working across all three modalities, including in-person interpreting, video remote interpreting (VRI), and over-the-phone interpreting (OPI). Within this group, most identified in-person interpreting as their dominant modality (n = 32), while smaller numbers identified VRI (n = 8) or OPI (n = 3) as dominant. Overall, these findings suggest that although interpreters frequently worked across multiple service delivery formats, in-person interpreting remained the dominant modality for much of the sample.

Respondents were also asked how many clinical specialty areas they regularly interpreted in. This question was included to better understand the breadth of clinical environments in which healthcare interpreters work.

Figure 3

Number of Clinical Specialty Areas Reported by Medical Interpreter Participants



As illustrated in Figure 3, many interpreters reported working across a broad range of specialty areas. The largest portion of the sample indicated working in 10 or more specialties (n = 75), followed by 6–10 specialties (n = 49). Smaller numbers reported working in 3–5 specialties (n = 24) or 1–2 specialties (n = 10). These findings reflect the wide scope of clinical exposure common in healthcare interpreting and suggest that many interpreters regularly adapt to diverse medical contexts, terminology, and communication demands.

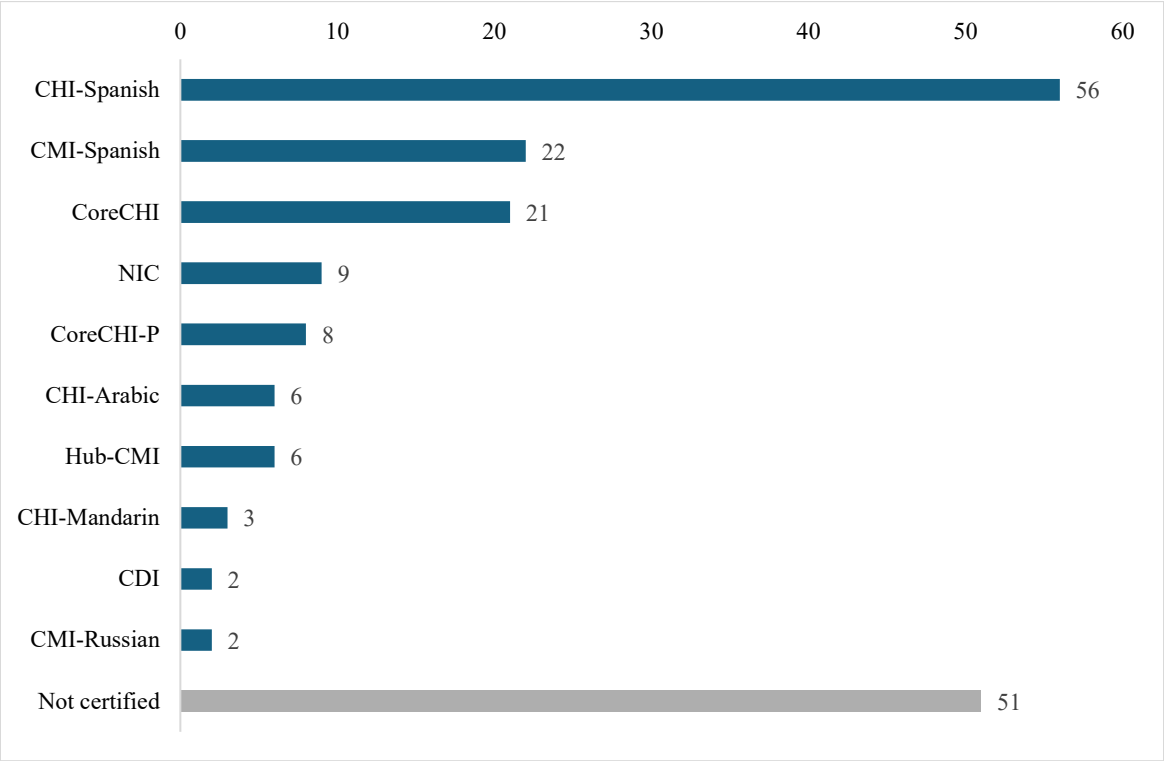
Professional Preparation and Qualifications

Participants reported a range of national certification credentials for spoken and signed language interpreters. Reported credentials included written, oral/performance-based, and language-specific healthcare interpreting certifications. Because some participants reported holding more than one certification, frequency exceeded the total number of interpreter respondents. Certification status was self-reported and was not independently verified as part of this study.

CHI™-Spanish was the most frequently reported credential (n = 56), followed by CMI-Spanish (n = 22) and CoreCHI™ (n = 14). Additional certifications included NIC (n = 9), CoreCHI™-P (n = 8), CHI™-Arabic (n = 6), Hub-CMI (n = 6), CHI™-Mandarin (n = 3), CDI (n = 2), and CMI-Russian (n = 2). Fifty-two participants reported not holding a professional certification (see Figure 4).

Figure 4

Professional Certification Status of Interpreter Respondents



For highest level of interpreter training completed, respondents reported a range of educational and professional preparation pathways. Open-ended responses that lacked sufficient detail were consolidated into the best-fitting categories based on the information provided.

Responses referencing degrees unrelated to interpreting were not categorized as interpreter-specific training.

The most frequently reported training pathway was completion of a 40+ hour medical interpreter training program (n = 93; see Figure 5b). Additional training included college or university certificate programs in interpreting (n = 30), master's degrees in interpreting (n = 12), bachelor's degrees in interpreting (n = 7), CEU workshops (n = 7), on-the-job training only (n = 7), and self-study (n = 3). None of the respondents reported having no formal training. None of the respondents had a PhD in interpreting. Some respondents reported having more than one form of interpreter training.

Respondents also reported a range of general educational backgrounds (see Figure 5a). The most frequently reported highest level of education was a bachelor's degree (n = 59), followed by a master's degree (n = 55). Additional respondents reported associate's degrees (n = 18), some college education (n = 12), doctoral or professional degrees (n = 10), and a high school diploma or GED (n = 3). Two participants preferred not to answer.

Figure 5

Educational and Professional Preparation of Medical Interpreter Respondents

Figure 5a: Highest Level of Education

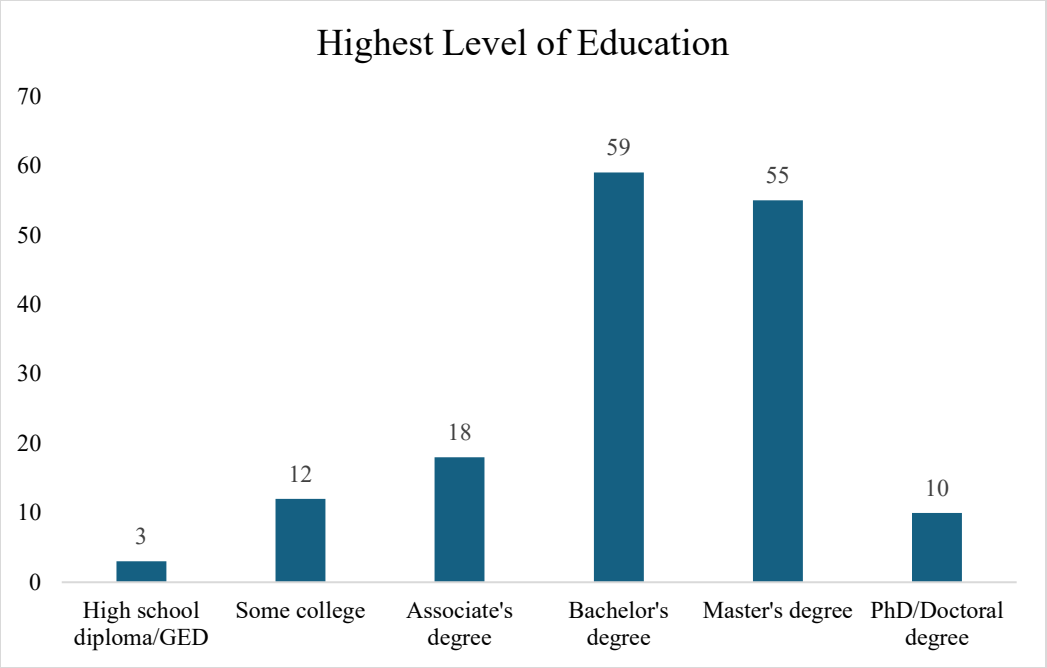
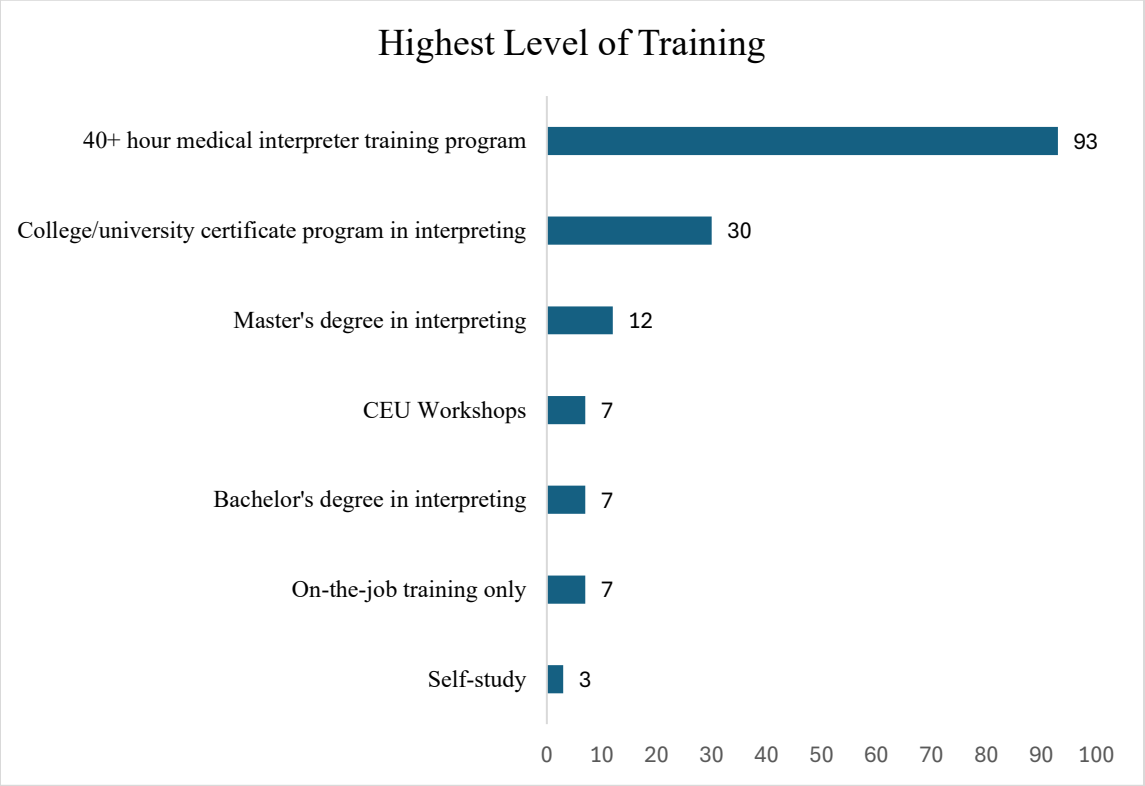


Figure 5b: Highest Level of Interpreter Training

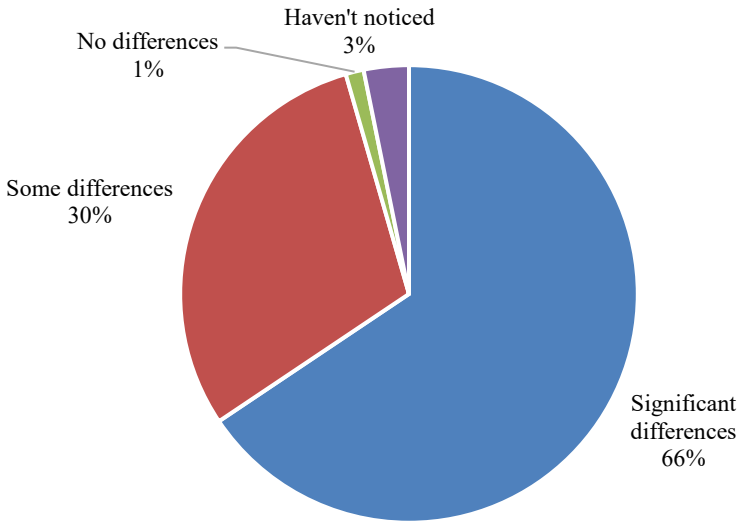


Interpreter Decision-Making and Intervention During Healthcare Encounters

Participants were asked whether they noticed differences in how they were able to support limited English proficient (LEP) patients when working in different interpreting modalities, including in-person interpreting, video remote interpreting (VRI), and over-the-phone interpreting (OPI). As shown in Figure 6, most interpreters reported noticing either significant differences (66%) or some differences (30%) in their ability to support LEP patients across modalities. Only a small percentage reported no differences (1%) or stated that they had not noticed differences (3%). These findings suggest that interpreting modality may influence how interpreters perceive their ability to support LEP patients beyond language transmission alone.

Figure 6

Perceived Differences in Supporting LEP Patients Across Interpreting Modalities



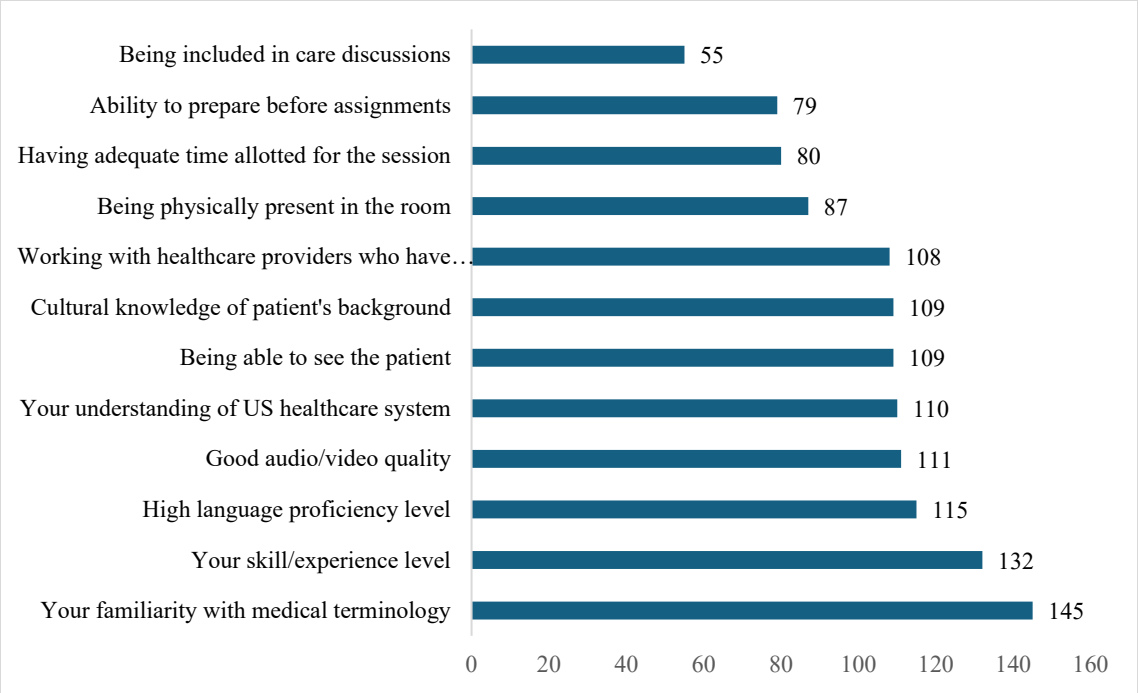
Participants were asked which factors they believed were essential for providing quality care to limited English proficient (LEP) patients and were permitted to select all factors that

applied. Responses reflected a broad range of linguistic, interpersonal, environmental, and systemic considerations that interpreters perceived as important to effective patient care.

Familiarity with medical terminology was the most frequently selected factor (n = 145), followed by interpreters' skill and experience level (n = 132), high language proficiency (n = 115), and good audio/video quality (n = 111). Respondents also frequently identified understanding of the U.S. healthcare system (n = 110), the ability to see the patient (n = 109), cultural knowledge of the patient's background (n = 109), and working with healthcare providers who had received training on how to work with medical interpreters (n = 108) as essential components of quality care. Additional factors included being physically present in the room (n = 87), having adequate time allotted for the session (n = 80), the ability to prepare before assignments (n = 79), and being included in care discussions (n = 55) (see Figure 7).

Figure 7

Factors Medical Interpreters Identified as Essential for Providing Quality Care to LEP Patients



In addition to the structured response options, 18 interpreters (11.3% of respondents) provided open-ended comments. Although this represented a relatively small subset of participants, several recurring themes emerged from these responses, including the importance of having background knowledge about the patient's case, opportunities to prepare prior to encounters, even briefly to research terminology or communicate with providers, respectful collaborative relationships with healthcare professionals, and continuity of care with patients and families over time. These comments further highlighted interpreters' perceptions that effective healthcare interpreting extends beyond language conversion alone and is influenced by preparation, collaboration, and ongoing relational context.

Interpreter respondents identified several factors that influenced them when they decided to intervene during potential communication issues (see Figure 8). The most frequently selected factor was the potential consequences if the misunderstanding continued (n = 150, 94.3%),

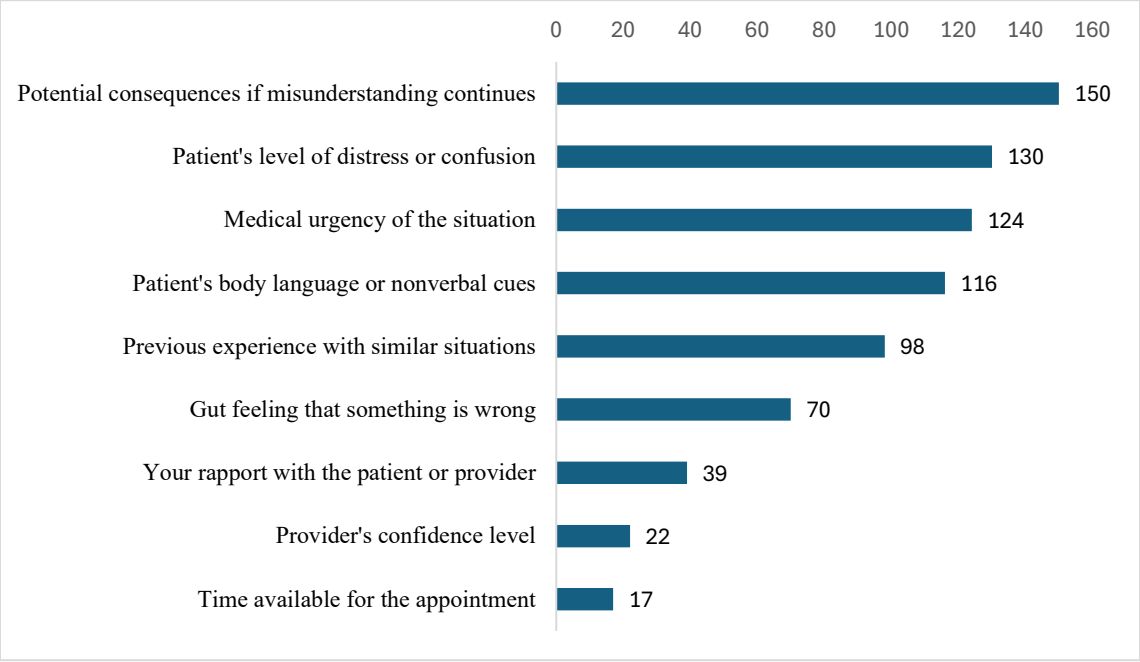
followed by the patient's level of distress or confusion (n = 130, 81.8%) and the medical urgency of the situation (n = 124, 78.0%).

Additional factors included the patient's body language or nonverbal cues (n = 116, 73.0%) and previous experience with similar situations (n = 98, 61.6%). Gut feeling that something was wrong was selected by 70 respondents (44.0%), while rapport with the patient or provider was selected by 39 respondents (24.5%). Provider confidence level (n = 22, 13.8%) and time available for the appointment (n = 17, 10.7%) were reported less frequently.

Because respondents could select more than one response option, percentages exceed 100%.

Figure 8

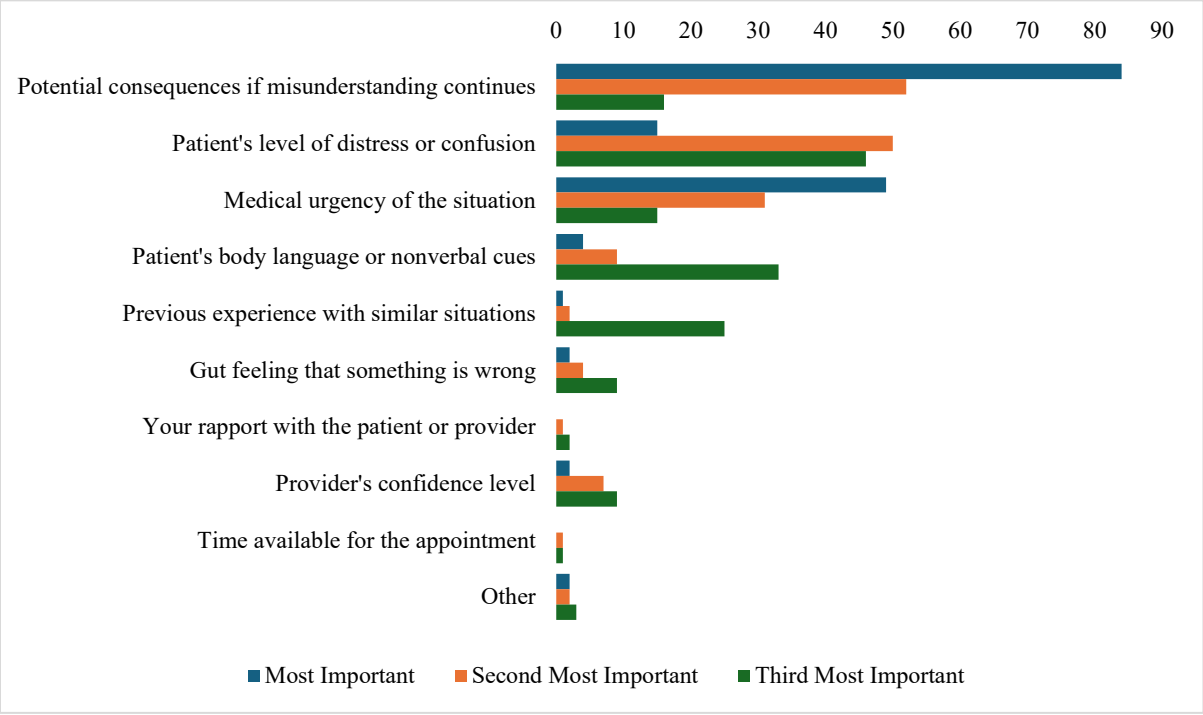
Factors Influencing Interpreter Decisions to Intervene During Potential Communication Issues



Sixteen respondents (10.1% of the sample) also provided additional write-in factors influencing intervention decisions. These included long utterances, the goals of the session, patient mental status, difficulty understanding provider or patient accents, repeated questioning suggesting lack of comprehension, interpreter concern that communication was not being fully understood, language register mismatches, cultural misunderstandings, family member intervention, providers overlooking patient body language, and situations in which providers' wording did not effectively convey their intended meaning.

Figure 9

Ranked Factors Influencing Interpreter Decisions to Intervene During Communication Issues



Interpreter respondents were also asked to rank the three most important factors influencing their decisions to intervene during potential communication issues (see Figure 9). The factor most frequently ranked as the single most important consideration was the potential

consequences if the misunderstanding continued (n = 84), followed by the medical urgency of the situation (n = 49). Patient distress or confusion was less frequently ranked as the most important factor (n = 15), but appeared prominently among second- and third-ranked responses.

For the second most important factor, the patient's level of distress or confusion was selected most frequently (n = 50), followed closely by the potential consequences if misunderstanding continued (n = 52) and the medical urgency of the situation (n = 31). Patient body language or nonverbal cues (n = 9) and provider confidence level (n = 7) were selected less frequently.

Among third-ranked responses, patient distress or confusion remained the most frequently selected factor (n = 46), followed by patient body language or nonverbal cues (n = 33) and previous experience with similar situations (n = 25). Additional third-ranked responses included medical urgency of the situation (n = 15), provider confidence level (n = 9), gut feeling that something was wrong (n = 9), and potential consequences if misunderstanding continued (n = 16).

Less frequently selected factors across all ranking categories included rapport with the patient or provider, time available for the appointment, and other write-in responses.

When interpreters were asked if they intervened in medical encounters based on instinct, responses suggested that most interpreters did not frequently intervene before fully analyzing a situation. "Rarely" was the most common response (n = 69, 43.4%), followed closely by "Sometimes" (n = 58, 36.5%). Far fewer respondents indicated that they intervened based primarily on instinct "Often" (n = 11, 6.9%) or "Always" (n = 4, 2.5%), while 17 respondents (10.7%) reported never doing so.

When asked whether they later realized they had considered factors they were not initially aware of when deciding to intervene, responses were more evenly distributed across categories. “Rarely” was selected most frequently (n = 51, 32.1%), followed by “Occasionally” (n = 47, 29.6%). Additionally, 38 respondents (23.9%) indicated they were “Not sure,” while fewer respondents reported this occurred “Frequently” (n = 9, 5.7%) or “Never” (n = 14, 8.8%).

Tasks Beyond Interpreting

Interpreter respondents were asked whether they had ever assisted patients directly with tasks beyond interpreting, defined in this study as activities extending beyond the accurate transfer of messages between parties, such as advocacy, emotional support, cultural mediation, logistical assistance, or other forms of direct patient support. The majority of respondents indicated that they had experienced situations in which they assisted patients directly either instead of or in addition to interpreting (n = 126, 79.2%). In comparison, 33 respondents (20.8%) reported they had not encountered or engaged in these situations.

Respondents who indicated they had assisted patients directly beyond interpreting were then asked how frequently they engaged in specific tasks commonly considered outside the traditional interpreter role (see Table 2). Reported frequencies varied across task categories.

Advocating for patient needs, defined in this study as speaking out to protect patients from serious harm or mistreatment, emerged as one of the most frequently reported activities beyond interpreting responsibilities. Fifty-two respondents reported “sometimes” advocating for patient needs, while 34 indicated doing so “often” and 18 “always.” Providing emotional support or comfort was also commonly reported, with respondents most frequently selecting “sometimes” (n = 51) and “rarely” (n = 43). Similarly, cultural explanation or mediation was

distributed across multiple frequency categories, including "sometimes" (n = 41), "rarely" (n = 37), and "often" (n = 23).

Several respondents also reported assisting patients with logistical concerns such as transportation, resources, or navigation. Thirty-nine respondents indicated they "sometimes" provided logistical information, while 37 selected "rarely" and 17 selected "often." Scheduling appointments or follow-up visits was reported less consistently, with the largest proportion of respondents indicating they "never" performed this activity (n = 67).

Some activities appeared less common overall. The majority of respondents reported "never" answering insurance or billing questions (n = 116) or explaining medical procedures or referral processes (n = 96). However, smaller numbers of respondents indicated engaging in these activities at least occasionally.

Although respondents who answered "no" to the previous question were instructed to select "never" for all follow-up activities, some responses did not follow this pattern. This inconsistency suggests that some participants may have interpreted the questions differently or reconsidered their experiences when responding to specific task categories.

Table 2

Frequency of Tasks Performed Beyond Language Interpretation without a Provider Present

Task	Always	Often	Sometimes	Rarely	Never
Providing a cultural explanation or mediation	20	23	41	37	39
Advocating for patient needs	18	34	52	29	29
Scheduling appointments or follow-up visits	16	32	20	18	67

Explaining medical procedures or referral processes	9	5	24	25	96
Providing emotional support or comfort	7	12	51	43	49
Answering insurance or billing questions	5	4	17	18	116
Providing logistical information (transportation, resources, navigation)	3	17	39	37	65

Respondents were also asked whether they had ever provided emotional support to patients during difficult medical situations despite professional guidelines encouraging interpreters to limit personal involvement with patients. Half of respondents indicated they "rarely" provided emotional support in these situations (n = 80, 50.3%). Another 41 respondents (25.8%) reported doing so "occasionally," while smaller proportions selected "never" (n = 29, 18.2%) or "frequently" (n = 9, 5.7%).

Emotional Support, Ethics, and Professional Boundaries

Interpreter respondents who indicated they had provided emotional support to patients during difficult medical situations were asked to identify the circumstances in which this support occurred. The most frequently selected circumstance was when culturally appropriate care was needed (n = 91, 57%), followed by delivering difficult news (n = 79, 50%) and during frightening procedures (n = 70, 44%). Emotional support was also commonly reported when patients were alone and distressed (n = 68, 43%). Fewer respondents selected situations in which no healthcare staff were immediately available (n = 34, 21%).

This survey item was unintentionally marked as mandatory. As a result, some respondents who indicated they had not provided emotional support in the previous question

entered responses such as “no” or “never” manually in the write-in section rather than skipping the item as intended.

In addition to the structured response categories, 22 respondents provided open-ended comments describing additional situations in which emotional support occurred. Several responses referenced emotional support developing through ongoing relationships with patients and families across repeated encounters. Others described situations involving grief, end-of-life care, frightening procedures, embarrassment, or patients experiencing distress without adequate emotional support from healthcare staff. Respondents also described culturally influenced expressions of comfort, including the use of respectful language, reassurance, physical gestures such as holding a patient’s hand, and providing comfort to children and families during difficult encounters. Some comments additionally reflected tension between empathy, institutional expectations, and professional neutrality, particularly among staff interpreters who reported developing long-term familiarity with patients and families.

Respondents who reported providing emotional support during difficult medical situations were also asked to rank the circumstances in which this support was most likely to occur (see Figure 10). Delivering difficult news was most frequently identified as the primary circumstance associated with providing emotional support (n = 35), followed by situations in which culturally appropriate care was needed (n = 28) and situations in which no healthcare staff were immediately available (n = 23).

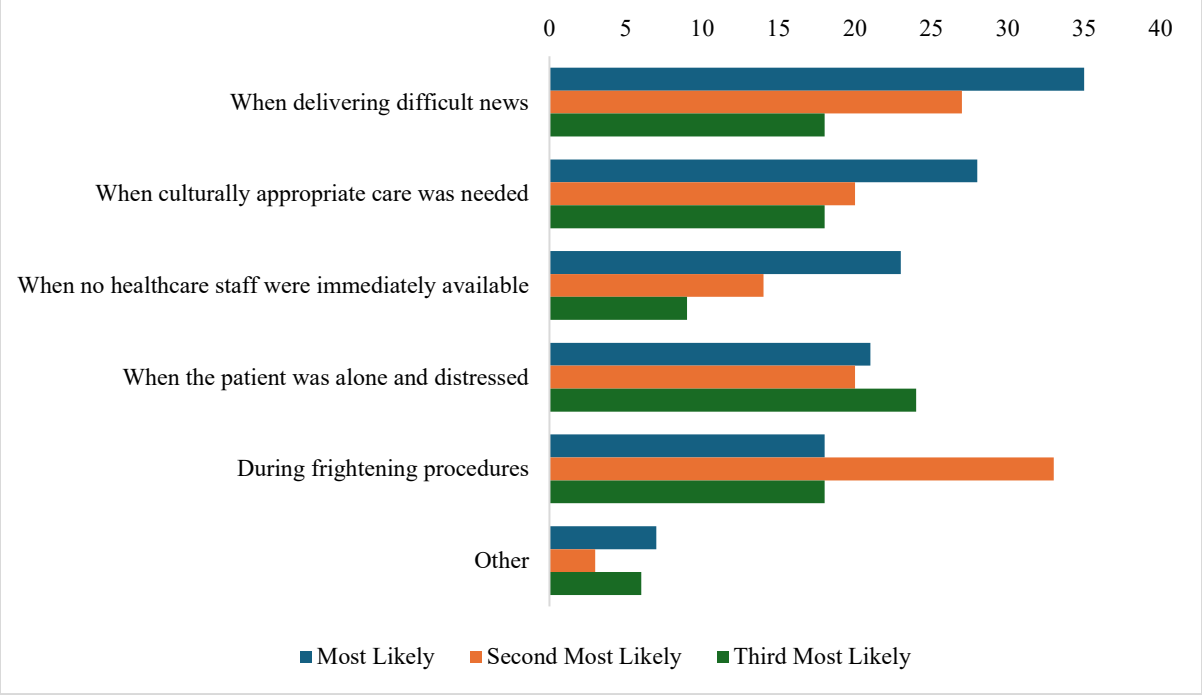
Frightening procedures emerged more prominently among second-ranked responses (n = 33), while situations involving patients who were alone and distressed appeared frequently across all ranking categories, including as the most frequently selected third-ranked circumstance

(n = 24). Additional responses highlighted circumstances involving culturally appropriate care, difficult news delivery, and situations categorized as "other."

Open-ended responses further suggested that emotional support often occurred in situations involving grief, fear, long-term rapport with patients and families, culturally appropriate expressions of comfort, and perceived lack of emotional support from healthcare staff.

Figure 10

Ranked Circumstances in Which Interpreters Reported Providing Emotional Support



When asked how they justified providing emotional support in relation to professional interpreting guidelines, the most frequently selected response was that it reflected "basic human compassion" (66%, n = 105) (see Figure 11). Half of respondents (50%, n = 79) viewed emotional support as advocacy for patient safety and wellbeing, while 32% (n = 51) framed it as

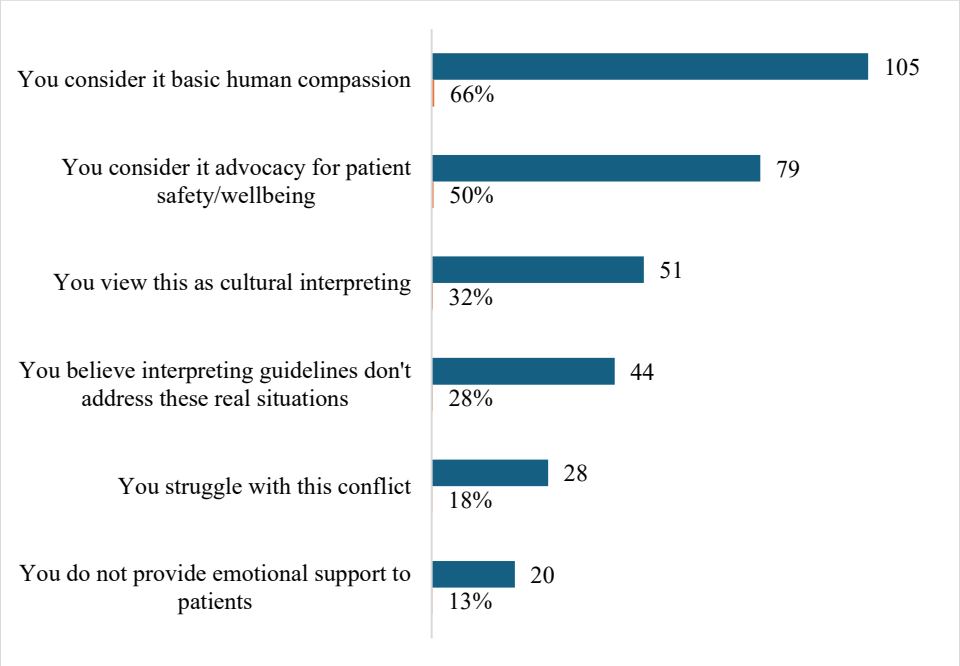
part of cultural interpreting. Additionally, 28% (n = 44) indicated that existing professional guidelines do not adequately address the realities of healthcare encounters.

At the same time, some interpreters reported tension surrounding emotional support and professional boundaries. Eighteen percent of respondents (n = 28) stated that they struggle with this conflict, while 13% (n = 20) reported that they do not provide emotional support to patients.

In addition to the fixed-response options, 11 interpreters provided written comments elaborating on how they reconciled emotional support with professional expectations. These responses highlighted themes related to compassion, ethical reasoning, professional boundaries, and the limitations of existing guidelines. The qualitative findings will be explored in greater detail in the qualitative analysis section.

Figure 11

Interpreter Justifications for Providing Emotional Support Within Professional Guidelines



Note. Participants could select more than one response option.

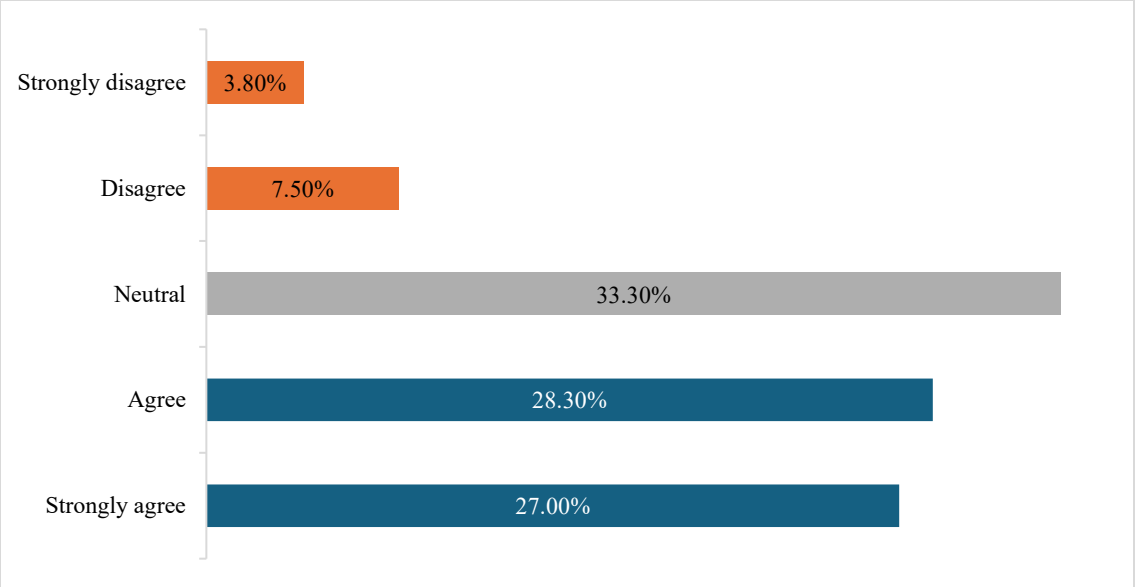
When asked whether providing compassionate support to patients should be considered an ethical interpreting practice, responses were mixed but generally leaned toward agreement (see Figure 12). Over half of respondents either agreed (28.3%, n = 45) or strongly agreed (27.0%, n = 43) that compassionate support should be considered ethical practice for medical interpreters. Neutral responses represented the single largest category at 33.3% (n = 53), suggesting that many interpreters may remain uncertain or conflicted about how compassionate support aligns with professional standards.

Relatively few respondents opposed the idea that compassionate support could be ethical interpreting practice. Seven and a half percent (n = 12) disagreed, while 3.8% (n = 6) strongly disagreed. Overall, the findings suggest that many interpreters view compassionate support as compatible with ethical practice, although a substantial proportion remain cautious or undecided regarding the role of emotional support within professional interpreting boundaries.

Respondents also provided written explanations regarding their views on compassionate support and interpreter ethics. These qualitative responses will be examined in greater detail in the qualitative analysis section.

Figure 12

Interpreter Beliefs About Compassionate Support as Ethical Practice



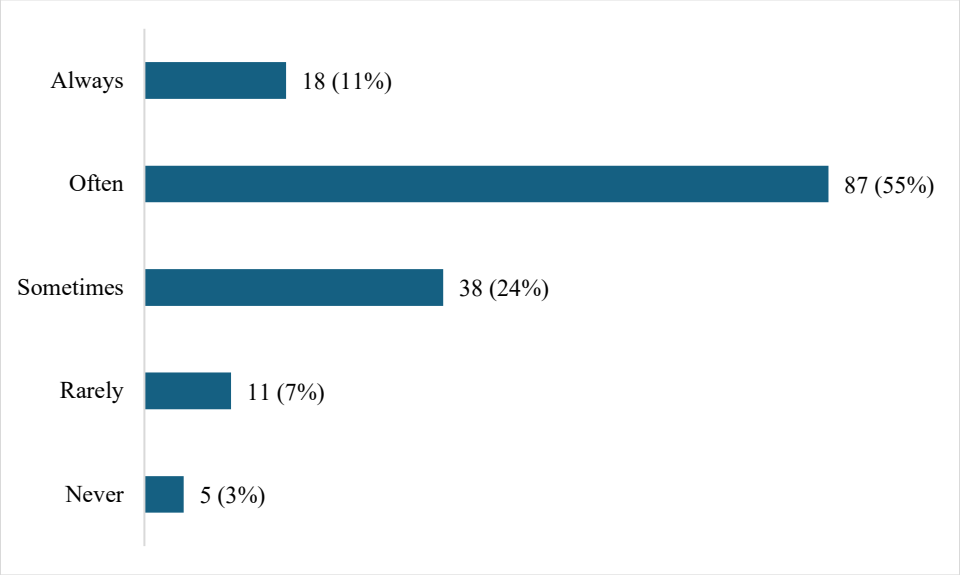
When asked how often they were the only member of the healthcare team familiar with a patient's cultural background or cultural nuances, interpreters overwhelmingly reported that this occurred on a regular basis (see Figure 13). The majority of respondents selected often (54.7%, n = 87), while 11% (n = 18) indicated that they were always the only person on the healthcare team with this level of cultural understanding.

Nearly one-quarter of respondents (24%, n = 38) reported that this occurred sometimes. In contrast, relatively few interpreters selected rarely (6.9%, n = 11) or never (3.1%, n = 5). These findings suggest that many interpreters perceive themselves as occupying a unique cultural role within healthcare encounters, particularly in situations where providers may have limited familiarity with the patient's cultural context.

Participants also submitted written responses describing how being the primary source of cultural understanding influenced their interactions with patients and healthcare providers. These qualitative findings will be discussed further in the qualitative analysis section.

Figure 13

Frequency of Interpreters Being the Only Team Member Familiar With Patient Cultural Backgrounds or Nuances

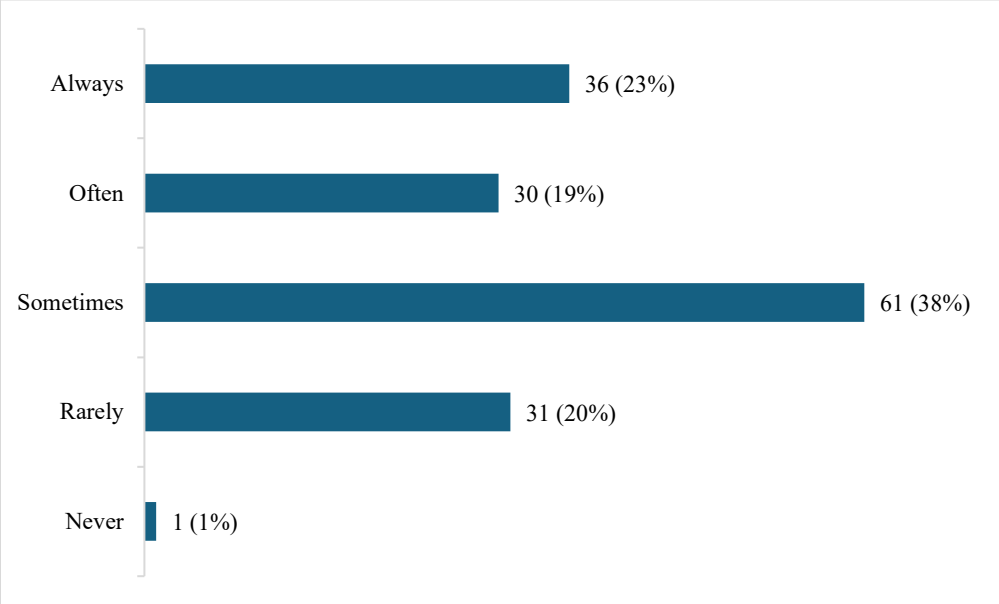


Interpreters reported varying levels of involvement in alerting healthcare providers to cultural misunderstandings that could affect patient care (see Figure 14). The largest proportion of respondents selected sometimes (38.4%, n = 61). However, more than two-fifths of participants indicated that they addressed these issues on a frequent basis, with 22.6% (n = 36) selecting always and 18.9% (n = 30) selecting often.

In comparison, 19.5% (n = 31) of respondents reported rarely intervening in situations involving cultural misunderstandings, while only one participant (0.6%) selected never. Taken together, the findings suggest that interpreters commonly perceive identifying and communicating cultural concerns as part of their interactions within healthcare encounters.

Figure 14

Frequency of Interpreters Alerting Providers to Cultural Misunderstandings Affecting Patient Care



Ethical Decision-Making

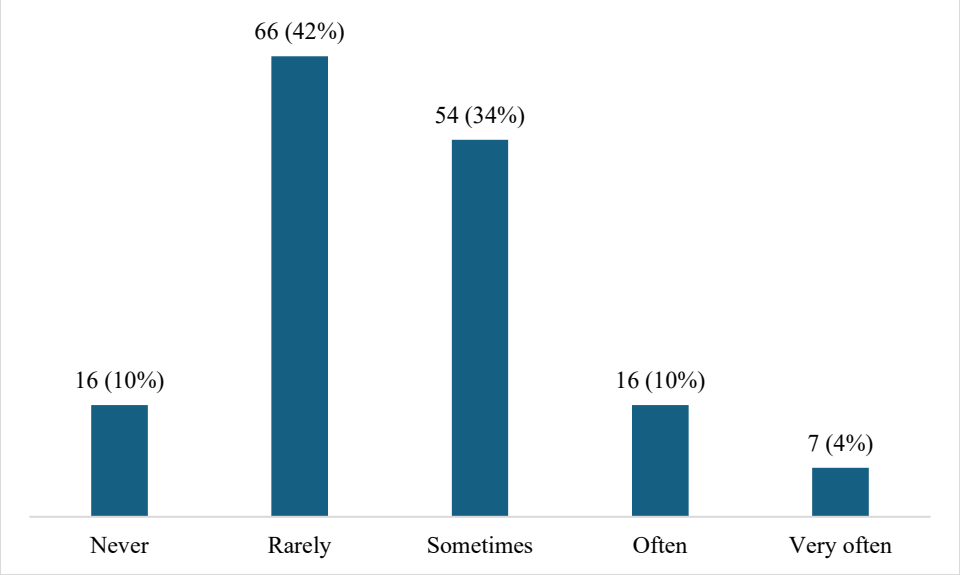
A large majority of interpreters reported encountering situations in which they felt they could support a patient but were uncertain whether doing so would align with professional interpreting guidelines. Overall, 83.6% of respondents (n = 133) indicated that they had experienced this type of ethical uncertainty, while 16.4% (n = 26) reported that they had not. These findings suggest that many interpreters regularly navigate situations in which professional boundaries and perceived patient needs may come into tension.

Although most interpreters reported experiencing this type of ethical uncertainty, the frequency varied. The largest proportion of respondents selected rarely (41.5%, n = 66), followed by sometimes (34%, n = 54) (see Figure 15). Smaller percentages indicated that these situations occurred often (10.1%, n = 16) or very often (4.4%, n = 7), while 10.1% (n = 16) selected never.

These findings suggest that ethical uncertainty related to supporting patients beyond interpreting may be relatively common across interpreters' careers, even if such situations do not occur routinely in day-to-day encounters.

Figure 15

Frequency of Ethical Uncertainty Regarding Support Beyond Interpreting



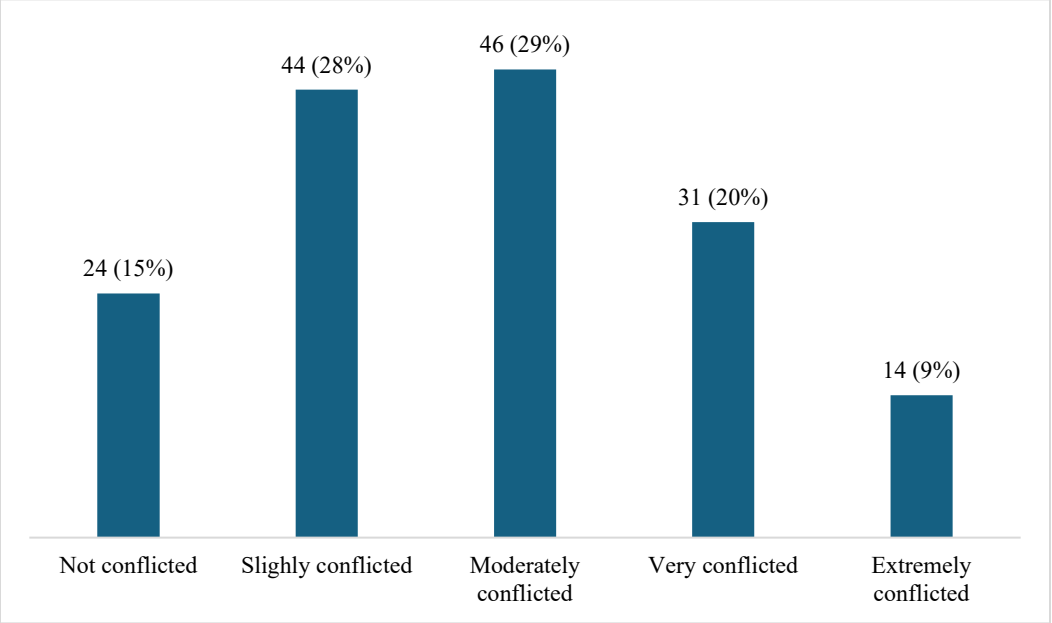
Among interpreters who experienced uncertainty about supporting patients beyond interpreting guidelines, levels of conflict varied (see Figure 16). The largest proportion of respondents reported feeling moderately conflicted (28.9%, n = 46), followed closely by slightly conflicted (27.7%, n = 44). However, a substantial number also described experiencing higher levels of conflict, with 19.5% (n = 31) selecting very conflicted and 8.8% (n = 14) selecting extremely conflicted.

Fifteen and one-tenth percent of respondents (n = 24) indicated that they did not feel conflicted in these situations. Overall, the findings suggest that many interpreters experience at

least some degree of ethical tension when balancing professional guidelines with perceived patient needs.

Figure 16

Level of Ethical Conflict Experienced in Situations Involving Support Beyond Interpreting



Situations involving patient understanding, discharge-related concerns, and emotional vulnerability were commonly identified as creating ethical conflict for interpreter respondents (see Figure 17). The most frequently selected situation involved patients agreeing to something interpreters suspected they did not fully understand (n = 102, 64%). Other commonly selected situations included patients being discharged without adequate understanding or resources (n = 93, 58%) and patients receiving difficult news without a support person present (n = 90, 57%).

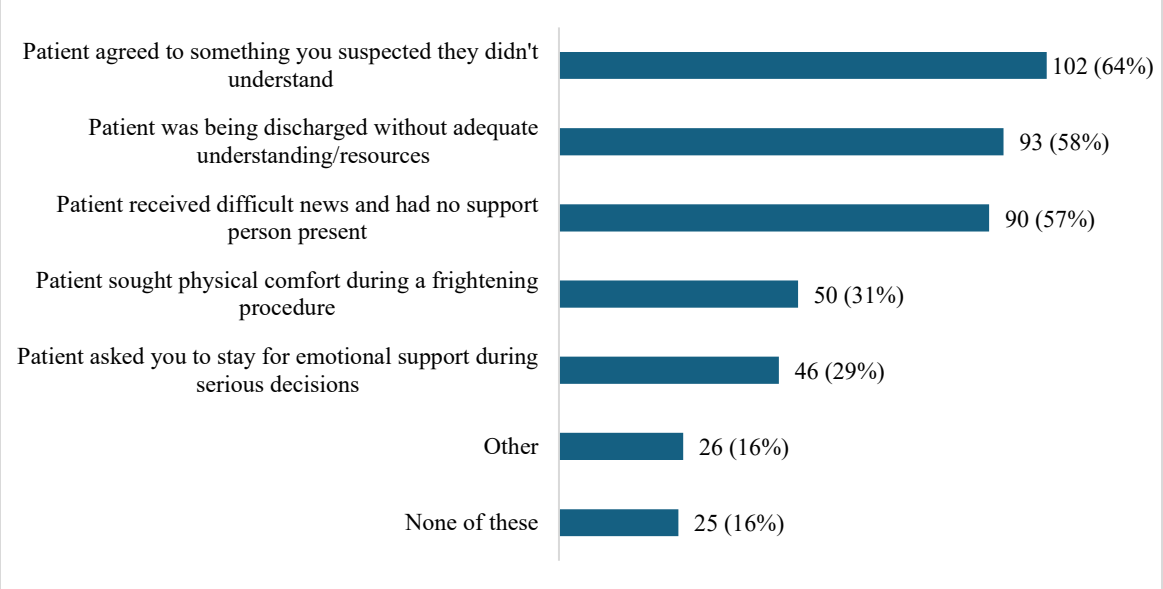
Additional situations included patients seeking physical comfort during frightening procedures (n = 50, 31%) and patients asking interpreters to remain present for emotional

support during serious medical decisions (n = 46, 29%). Twenty-six participants (16%) selected "Other," while 25 participants (16%) selected "None of these."

Several participants also provided written comments describing additional situations that created ethical conflict. These responses varied in specificity, and some participants selected "Other" without providing additional explanation. These responses will be explored in greater detail in the qualitative analysis section.

Figure 17

Situations Creating Ethical Conflict for Medical Interpreters



To better understand which situations created the greatest ethical tension, respondents were also asked to rank the scenarios they found most conflict-inducing (see Table 3). Situations involving patients agreeing to something interpreters suspected they did not understand were most frequently ranked as creating the highest level of conflict (n = 51). Situations involving patients receiving difficult news without a support person present and patients being discharged

without adequate understanding or resources were also consistently ranked among the top sources of ethical conflict across all three ranking categories.

Table 3

Ranked Situations Creating Ethical Conflict for Medical Interpreters

Clinical Situations	Most Conflict	Second Most Conflict	Third Most Conflict
Patient agreed to something you suspected they didn't understand	51	40	21
Patient received difficult news and had no support person present	33	37	29
Patient was being discharged without adequate understanding/resources	22	30	29
Other	17	15	28
Patient sought physical comfort during a frightening procedure	14	12	19
None of these	13	14	18
Patient asked you to stay for emotional support during serious decisions	9	11	15

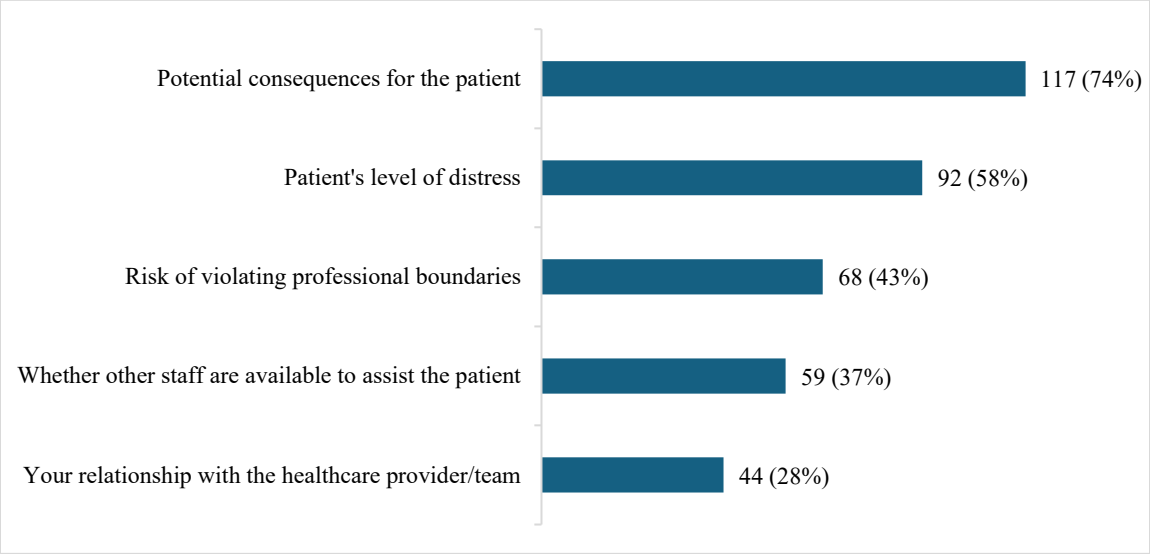
Following questions about ethical conflict, interpreters were asked which factors typically influenced their decisions about whether to act beyond traditional interpreting boundaries (see Figure 18). The most frequently selected factor was potential consequences for the patient (n = 117, 74%), followed by the patient's level of distress (n = 92, 58%). Risk of violating professional boundaries was also commonly selected (n = 68, 43%), suggesting that interpreters often weighed patient needs alongside awareness of professional expectations.

Additional influences included whether other staff were available to assist the patient (n = 59, 37%) and the interpreter's relationship with the healthcare provider or care team (n = 44, 28%).

Nine participants also provided written responses in the "Other" category. Several of these comments referenced concerns related to patient harm, informed consent, cultural or linguistic misunderstandings, and gaps in available patient support. Some respondents also described relying heavily on interpreter training, ethics, institutional roles, and advocacy responsibilities when making decisions in these situations. These responses will be explored further in the qualitative analysis section.

Figure 18

Factors Influencing Interpreters' Decisions to Perform Tasks Beyond Interpreting



Interpreters were also asked how frequently they experienced tension between professional guidelines about staying within interpreting boundaries and situations where they felt they could support a patient. The largest proportion of respondents reported experiencing this

tension “sometimes” (n = 65, 40.9%), followed by “rarely” (n = 60, 37.7%). Smaller percentages reported experiencing this tension “often” (n = 16, 10.1%) or “always” (n = 6, 3.8%), while only 12 respondents (7.5%) indicated they never experienced this type of conflict.

Respondents were then asked to describe how they typically resolved these conflicts in practice. These responses will be explored further in the qualitative analysis section.

Interpreter Integration Within the Healthcare Team

Interpreters were asked how frequently healthcare providers consulted with them regarding cultural and linguistic considerations in patient care. Consultation regarding linguistic considerations occurred somewhat more frequently than consultation regarding cultural considerations; however, “rarely” remained the most common response for both categories.

For cultural considerations, nearly half of respondents reported that providers “rarely” consulted them (n = 73, 45.9%), while 47 respondents (29.6%) indicated this occurred “sometimes.” Similarly, for linguistic considerations, the largest proportion of respondents reported that providers “rarely” consulted them (n = 63, 39.6%), followed by “sometimes” (n = 53, 33.3%).

However, interpreters reported that when providers did consult them, their suggestions were frequently used. Fifty-one respondents (32.1%) indicated providers “often” used their suggestions, while 36 respondents (22.6%) reported providers “always” used them. In contrast, only 15 respondents (9.4%) reported their suggestions were “rarely” used, and 2 respondents (1.3%) indicated providers “never” used them. Twenty-one respondents (13.2%) selected “Not applicable,” indicating providers did not consult them.

Additionally, 62 respondents (39%) reported having been involved in providing training to healthcare providers regarding working with interpreters or LEP patients, while 97 respondents (61%) indicated they had not participated in this type of educational activity.

Among interpreters who reported participating in educational initiatives, respondents were able to select multiple training activities. The most frequently selected activity was training other interpreters (26%, n = 42), followed closely by in-service training for healthcare providers (25%, n = 40). Conference presentations were also commonly reported (21%, n = 34), along with institutional educational initiatives (19%, n = 31). One-on-one mentoring or guidance was identified by 18% (n = 28) of respondents, while 16% (n = 26) reported involvement in 40+ hour medical interpreter training programs (see Figure 19).

Additional forms of educational involvement included internal interpreter training (15%, n = 24), cultural competency training (13%, n = 20), specialty-specific training such as ICU or emergency department education (9%, n = 15), online modules or educational materials (9%, n = 14), and grand rounds presentations (8%, n = 13). Smaller numbers of participants reported involvement in college or university courses (6%, n = 9) and community education programs (6%, n = 9).

Open-ended responses further contextualized the wide range of educational and collaborative contributions interpreters make within healthcare systems. Participants described distributing fact sheets, printable guides, and interpreter service contact information; participating in simulation training; serving on panels for medical students; assisting with new employee orientation and onboarding; consulting for research institutions; and providing informal “in-the-moment” guidance to providers during clinical encounters. Several respondents also referenced participating in training modules focused on how to work effectively with

interpreters, while others described serving as institutional resources for interpretation and translation questions during meetings and committee work.

Figure 19

Educational and Training Roles Reported by Medical Interpreters

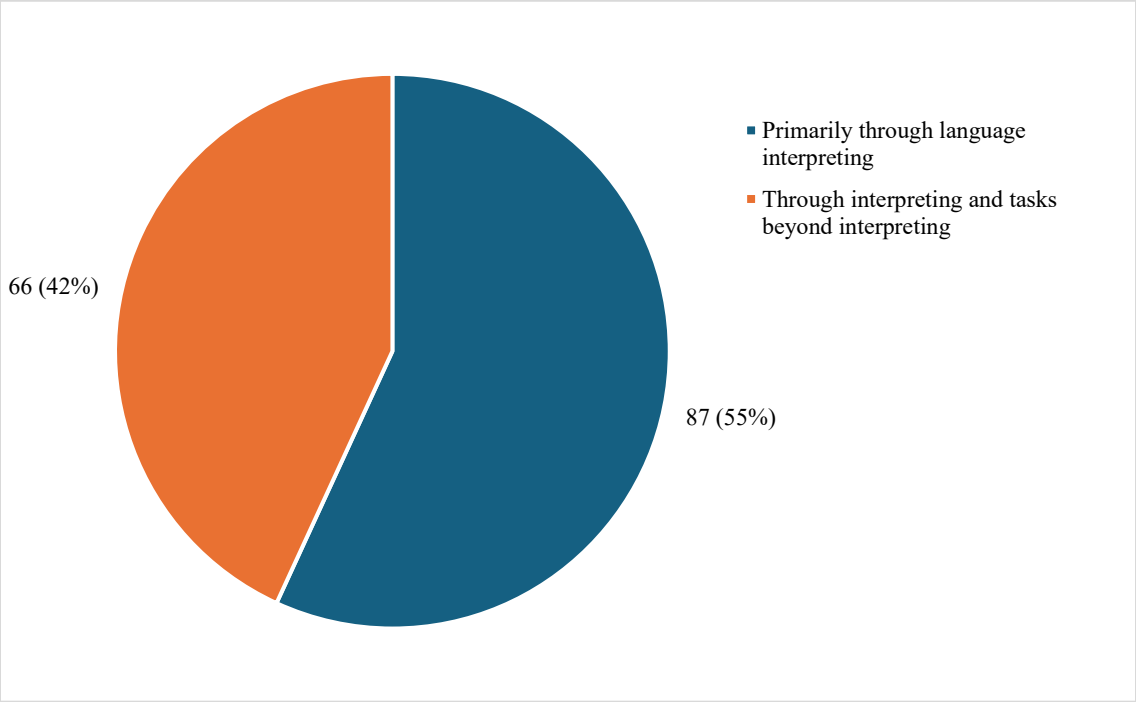
When asked how they believed they contributed to patient outcomes, most interpreters identified their role as extending beyond language interpreting alone. While 54.7% (n = 87) reported contributing primarily through language interpreting, 41.5% (n = 66) indicated they contributed through both language interpreting and tasks beyond interpreting. Only 1.3% (n = 2) reported being unsure of how they contributed to patient outcomes (see Figure 20).

Although only four participants provided additional written comments, these responses further illustrated how some interpreters conceptualized their broader contributions to patient

care. One participant emphasized the importance of remaining "calm, composed, present, attentive," while conveying empathy verbally and nonverbally during video remote interpreting encounters. Other respondents highlighted cultural brokerage and cultural competence as important aspects of their role. One participant also described contributing indirectly to patient outcomes by helping physicians present research findings in ways that laypeople could more easily understand.

Figure 20

Interpreters' perceptions of how they contribute to patient outcomes



Perceived Contributions and Professional Confidence

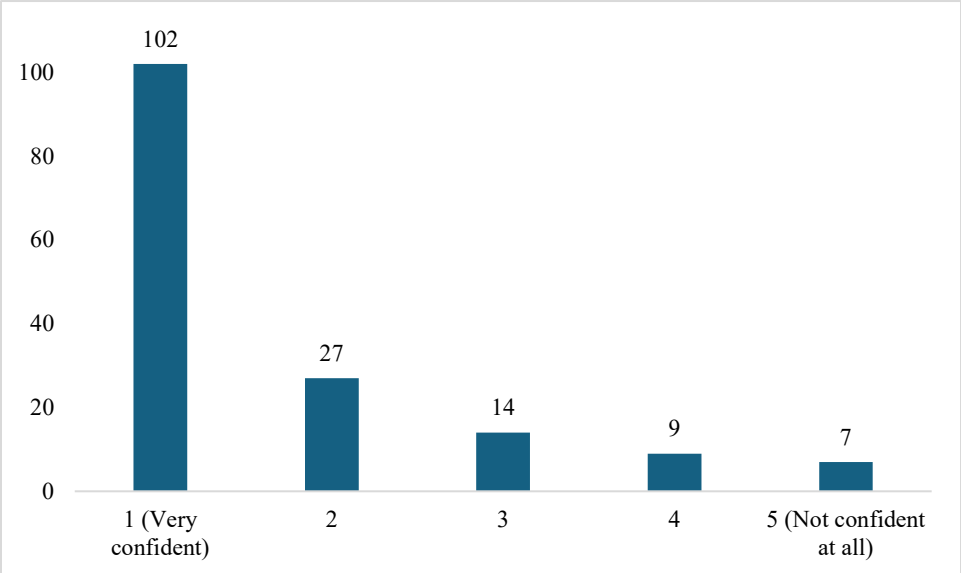
When asked about their confidence in maintaining professional interpreting ethics while providing emotional support to patients, most respondents reported high levels of confidence.

The survey used a 5-point scale in which 1 represented "Very confident" and 5 represented "Not at all confident," with intermediate values left unlabeled. Nearly two-thirds of respondents (64.2%, n = 102) selected "Very confident," while an additional 17.0% (n = 27) selected 2 on the scale. Smaller numbers selected 3 (8.8%, n = 14), 4 (5.7%, n = 9), or "Not at all confident" (4.4%, n = 7).

Interpreters also reported high levels of familiarity with formal professional ethics and standards for medical interpreters. The survey used a 5-point scale in which 1 represented "Very familiar" and 5 represented "Not at all familiar," with intermediate values left unlabeled. Most respondents (79.2%, n = 126) selected "Very familiar," while 13.2% (n = 21) selected 2 on the scale. Smaller numbers selected 3 (3.8%, n = 6) or "Not at all familiar" (3.8%, n = 6). No participants selected 4 on the scale (see Figure 21).

Figure 21

Confidence in maintaining ethics while providing emotional support



Interpreters also reported high levels of familiarity with formal professional ethics and standards for medical interpreters. The survey used a 5-point scale in which 1 represented "Very familiar" and 5 represented "Not at all familiar," with intermediate values left unlabeled. Most respondents (79.2%, n = 126) selected "Very familiar," while 13.2% (n = 21) selected 2 on the scale. Smaller numbers selected 3 (3.8%, n = 6) or "Not at all familiar" (3.8%, n = 6). No respondents selected 4 on the scale. Together, these findings suggest that most interpreters viewed themselves as both knowledgeable about professional ethics and confident in their ability to maintain ethical standards while providing emotional support to patients.

Qualitative Findings

Nine open-ended survey questions were analyzed using thematic analysis to identify recurring patterns, concepts, and experiences across participant responses. The questions explored interpreters' experiences related to emotional support, ethical decision-making, cultural mediation, patient advocacy, professional boundaries, collaboration, and contributions beyond language interpreting. Responses were reviewed iteratively and organized into major themes that emerged consistently across the dataset.

The qualitative findings were used to expand and contextualize quantitative survey results by providing additional insight into interpreters' lived experiences and perceptions within healthcare settings. Representative participant quotations were selected to illustrate major themes. To protect confidentiality, participant responses were anonymized using numerical identifiers (e.g., Interpreter 14).

Interpreter as Providers of Human-Centered Care

One of the strongest themes to emerge from the qualitative data was interpreters' descriptions of healthcare interpreting as fundamentally human work rather than a purely linguistic task. Across responses, participants described providing practical assistance, emotional presence, and compassionate support to patients during moments of vulnerability. While interpreters differed in their views regarding the appropriate limits of these activities, many emphasized that healthcare encounters involve human needs that extend beyond the transmission of words alone.

A recurring pattern involved interpreters describing small acts of practical assistance that helped patients navigate healthcare environments. Participants reported assisting patients with finding hospital departments, locating resources, navigating appointments, and managing basic needs when other staff were unavailable. One interpreter described "checking with RN to grab water for a patient in in person sessions and taking to them, or bringing a blanket if cold, or handing a phone/purse to them" (Interpreter 20). Others reported "directing patients how to get to different departments" (Interpreter 22), "helping patients find their way around the hospital" (Interpreter 99), and providing physical assistance to elderly patients and parents with young children by carrying belongings or offering physical support when needed (Interpreter 147). These examples were often described not as formal responsibilities, but as responses to immediate needs encountered during the course of patient care.

Several participants also described situations in which they became an important source of support for patients who were frightened, isolated, or experiencing significant emotional distress. Interpreters recounted remaining with patients during difficult moments, listening to concerns, and providing comfort through their presence. One interpreter shared, "I've held a mom when doctors were working on her son in the ICU" (Interpreter 145), while another

described supporting a young mother who had received devastating pregnancy-related news and was struggling to process the information alone (Interpreter 102). Participants frequently referenced situations in which patients lacked family support or were navigating serious diagnoses without loved ones present. As one interpreter explained, “Many times the patient doesn’t have any family member or a support system. Facing some bad news about his/her health is extremely hard” (Interpreter 48).

Beyond direct assistance, interpreters repeatedly emphasized the importance of emotional presence during healthcare encounters. Participants described communication as encompassing far more than the exchange of spoken words. One interpreter noted that “the tone of voice and the words chosen by the interpreter in difficult situations is what the patient is going to remember” (Interpreter 2). Another stated that patients often feel safer when interpreters demonstrate that they are “human” rather than distant or detached (Interpreter 87). Several respondents described building rapport with patients so they would feel comfortable expressing concerns and asking questions. As Interpreter 151 explained, a key aspect of the role is to “establish a positive rapport with every patient so that they feel understood and free to express themselves.”

Perhaps the most consistent sentiment throughout the responses was the belief that interpreters should not be expected to function as emotionless conduits. Numerous participants explicitly rejected descriptions of interpreters as robotic or machine-like. One participant wrote, “Human relations. Many times we are expected to act ‘robotically’ when the reality is that we deal with people/humans and we need to also show our own humanity” (Interpreter 47). Similar perspectives appeared repeatedly throughout the dataset. Participants stated that “we are not robots” (Interpreters 63, 85, 153), “interpreters are not machines” (Interpreter 149), and that

"acting like we aren't [human] is inhumane" (Interpreter 24). Another interpreter summarized this perspective by stating, "We're not robots, we're people, and it's human nature to want to support someone who is struggling right in front of us" (Interpreter 35).

At the same time, participants did not express unanimous agreement regarding the extent to which emotional support should be incorporated into the interpreter's role. While many respondents viewed compassion as a natural and necessary component of patient-centered communication, others emphasized the importance of maintaining professional boundaries. Interpreter 15 stated that "giving and receiving emotional support is highly individual and requires expertise," while Interpreter 72 noted that building rapport should primarily remain the responsibility of healthcare providers. Several respondents described attempting to balance compassion with professionalism. As Interpreter 130 explained, "The patients need to feel that we care for them but we can not get too attached to them." Similarly, Interpreter 154 described compassionate support as acting "in the patient's best interests, without aligning emotionally with them."

Although participants differed in where they believed professional boundaries should be drawn, responses consistently reflected the view that healthcare interpreting involves relational and human dimensions in addition to language transfer. Whether through practical assistance, emotional presence, rapport-building, or compassionate communication, many interpreters described their work as helping patients feel understood, supported, and less alone during some of the most vulnerable moments of their lives.

Negotiating Professional Boundaries and Ethical Tensions

Another major theme that emerged from the qualitative responses involved interpreters' ongoing efforts to navigate professional boundaries, ethical obligations, and patient needs. Participants frequently described healthcare encounters as situations that could not always be resolved through rigid application of professional standards alone. Rather than viewing ethics as a fixed set of rules, many interpreters described engaging in continuous judgment about when to intervene, when to remain silent, and how to balance professional expectations with the realities of patient care.

Many participants described role boundaries as a source of ongoing tension rather than certainty. One interpreter reflected, "I have to abide by my code of ethics and standards of practice, but where do my protocols place my human side?" (Interpreter 31). Another described the issue as "a balance of our COE and human compassion" (Interpreter 146), while Interpreter 12 stated, "I think we have gotten too rigid in our emphasis on role boundaries and impartiality to the point we are afraid to act human." These responses reflected a broader pattern in which interpreters frequently acknowledged professional standards while simultaneously questioning how those standards should be applied in emotionally complex situations.

Participants varied substantially in how they conceptualized the interpreter role. Some respondents strongly endorsed conduit-based approaches and emphasized maintaining strict professional boundaries. One participant stated, "I stick by 'interpreter is a conduit'" (Interpreter 18). Another emphasized that "it is important to remain within interpreter role boundary" (Interpreter 1), while others argued that emotional support should remain the responsibility of healthcare providers rather than interpreters (Interpreters 37, 84, 121). Several respondents expressed concern that increased involvement could compromise impartiality, create confusion about professional roles, or undermine effective communication. As Interpreter 84 explained,

"Providing compassionate support is subjective and could change from one interpreter to another." Similarly, Interpreter 76 cautioned that crossing established boundaries could increase liability and contribute to emotionally charged situations that extend beyond the interpreter's scope of practice.

At the same time, many interpreters questioned whether strict conduit models adequately reflected the realities of healthcare encounters. Participants repeatedly described situations involving fear, grief, isolation, or communication breakdowns in which they felt compelled to exercise judgment beyond literal message transfer. One interpreter observed that "impartiality has been confused with don't talk to the patient" (Interpreter 26), while another stated, "Because we are human. Our ethical and professional framework and our ability to be compassionate humans are not mutually exclusive" (Interpreter 67). Interpreter 25 similarly explained that "our role and ethics are clearly defined and work well; however, as a human and a language professional, we know when we can move the needle more depending on the situation."

Rather than relying on a single decision-making framework, participants frequently described evaluating each situation individually. Responses often included phrases such as "depends on the situation," "case by case," and "gray area." Interpreters described considering factors such as patient vulnerability, emotional distress, potential consequences, provider availability, and overall patient wellbeing when determining how to respond. One participant stated, "If I strongly believe it will influence the care, outcome or cause unnecessary distress to an already severely ill person, I resort to judgment, lesser of two evils" (Interpreter 5). Another explained, "It depends, sometimes I let my instinct win other times I stay away from crossing my boundaries" (Interpreter 19). Several respondents referenced relying on intuition, experience,

ethical judgment, or what they described as a "moral compass" when faced with difficult situations.

Participants also provided examples of circumstances in which professional boundaries became particularly difficult to navigate. Some recounted situations where they believed intervention benefited patients, while others described experiences that reinforced the importance of caution. One interpreter recalled advising a patient regarding the use of a work-related name during a medical encounter, only to later discover that the advice contributed to a fraud investigation, which "ended up being a mess" (Interpreter 155). Another participant described reassuring a distressed patient who feared a potential tumor by sharing personal observations from years of interpreting experience (Interpreter 148). These examples illustrated how quickly interpreters can move beyond traditional role expectations when attempting to comfort or assist patients.

A recurring source of tension involved the relationship between compassion and impartiality. Some participants viewed compassion as compatible with professional ethics. Interpreter 86 stated that "caring for others should not only be done by providers, interpreters also have a duty of care." Others viewed emotional support as potentially conflicting with neutrality. As Interpreter 29 explained, "We should be compassionate with our patients all the time, but we cannot be a compassionate support since we are supposed to be impartial." Similarly, Interpreter 121 argued that offering reassurance beyond limited expressions of sympathy could create unrealistic expectations and conflict with the interpreter's professional role.

Despite these differences, many participants agreed that existing ethical guidance does not always address the realities of healthcare encounters. Several respondents described

situations involving patients who were frightened, isolated, grieving, or seeking emotional support in ways that did not fit neatly within existing role definitions. One interpreter remarked that "we have enough [responsibilities], maybe they should be rewritten to address real situations" (Interpreter 154). Another described ethical decision-making in healthcare interpreting as "an ethical gray area" (Interpreter 61), while others emphasized that healthcare encounters frequently require balancing professional obligations with compassion, patient wellbeing, and the realities of human interaction.

Overall, participants demonstrated strong awareness of professional ethics and role boundaries, yet responses revealed substantial variation in how those boundaries were interpreted and applied. While some interpreters favored strict adherence to traditional role definitions, others described a more flexible approach grounded in situational judgment, patient needs, and professional experience. Across perspectives, participants consistently portrayed ethical decision-making as an active and ongoing process rather than a simple application of predetermined rules.

Interpreters as Cultural Mediators and Communication Specialists

Participants repeatedly emphasized that healthcare interpreting involved navigating layers of meaning that extended far beyond literal translation. Rather than viewing their role solely as transmitting words between languages, many respondents described serving as cultural mediators and communication specialists who help patients and providers understand one another across linguistic, cultural, emotional, and interpersonal differences.

A recurring pattern throughout the responses involved interpreters identifying cultural factors that influenced how healthcare information was communicated, understood, and acted

upon. Participants described recognizing culturally shaped beliefs, communication styles, family dynamics, and healthcare expectations that were not immediately apparent to providers. One interpreter explained that "being the only person familiar with the patient's cultural background makes me more aware of details that may seem simple to me but are often misunderstood by the healthcare provider" (Interpreter 100). Another participant described interpreters as "not only being a cultural broker, but a humanity broker, as well" (Interpreter 21). These responses reflected the perception that interpreters often occupied a unique position within healthcare encounters, possessing insight into both the patient's cultural perspective and the provider's expectations.

Many respondents described cultural mediation as helping providers understand how patients interpreted healthcare information within their own cultural context. One interpreter explained that "medicine is very different between countries" and characterized interpreters as "a bridge between two different systems and ways of delivering medicine. A diplomat. Beyond words" (Interpreter 120). Another participant described informing a nutritionist that recommendations regarding tortilla consumption required additional cultural context because standard serving sizes were often understood differently within some Latino communities (Interpreter 37). Similarly, Interpreter 39 described intervening when a provider advised a patient that eating eggs was acceptable without clarifying quantity, recognizing that the provider and patient had very different cultural assumptions regarding what constituted a reasonable amount.

Participants also emphasized that effective communication involved far more than vocabulary and grammar. Respondents repeatedly referenced tone, pacing, body language, emotional expression, and contextual understanding as essential components of healthcare communication. One participant stated that "communication is more than just words" and noted

that factors such as demeanor, tone of voice, body language, misunderstandings, and willingness to ask questions all influence how healthcare information is received (Interpreter 93). Another interpreter explained that a "medical interpreter's role should include not only accurate transmission of information, but also pragmatic and cultural mediation to ensure that messages are understood as intended across cultural contexts" (Interpreter 136).

Several participants described situations in which literal interpretation alone was insufficient to achieve meaningful communication. One respondent noted that patients in distress may need to hear information in a way that feels culturally familiar rather than receiving a direct linguistic rendering of the original message (Interpreter 32). Another interpreter observed that healthcare providers do not always offer comfort in ways that patients perceive as meaningful within their cultural framework, which can influence patient trust and confidence in their care (Interpreter 43). Participants frequently described adapting communication strategies to preserve intended meaning while remaining faithful to the content of the interaction.

Trust emerged as another important aspect of this theme. Many respondents described interpreters as individuals whom patients often viewed as safe, approachable, and culturally familiar during stressful healthcare encounters. One participant explained that patients "lean on you because they see you as someone safe because you speak their language" (Interpreter 147). Another noted that "patients trust more the person speaking their language than the provider," particularly during frightening or emotionally charged situations (Interpreter 5). Several interpreters suggested that rapport, empathy, and culturally responsive communication helped patients feel more comfortable expressing concerns, asking questions, and participating in their care.

Participants also described serving as communication specialists who identified misunderstandings that others in the encounter had overlooked. One interpreter recounted an oncology appointment in which providers mistakenly assumed a patient understood English well enough to follow complex discussions regarding radiation therapy. After overhearing the patient express confusion and fear, the interpreter encouraged her to request interpretation for the remainder of the encounter, ultimately improving her understanding of the treatment plan (Interpreter 5). Other respondents described facilitating teach-back techniques, recognizing confusion despite verbal agreement, and helping providers simplify explanations when patients appeared overwhelmed or uncertain. One participant described identifying that a family could not read or write in Spanish during a complex cancer consent process, prompting providers to modify their communication approach to ensure understanding (Interpreter 91).

Several participants emphasized that interpreters are often uniquely positioned to recognize cultural misunderstandings and communication barriers before they escalate. As one respondent explained, “sometimes the Interpreter is the only person who understands the cultural significance of the interactions and reactions to information” (Interpreter 100). Another participant noted that patients may not connect with or trust an interpreter who appears disconnected from their cultural experience (Interpreter 100). These responses reflected the belief that cultural understanding, communication expertise, and interpersonal awareness are closely interconnected components of effective healthcare interpreting.

Overall, participants described cultural mediation and communication management as ongoing and embedded aspects of healthcare interpreting rather than occasional additional tasks. Responses consistently suggested that interpreters were frequently relied upon to clarify meaning, contextualize patient reactions, facilitate understanding, and bridge differences in

communication styles, healthcare expectations, and cultural perspectives. Across responses, interpreters portrayed their role as helping ensure that communication was not only translated, but genuinely understood.

Interpreters Navigating Gaps in Patient Care

Another prominent theme involved interpreters describing situations in which they helped patients navigate gaps in healthcare systems, services, and processes that extended beyond direct language interpretation. Participants frequently portrayed themselves as recognizing unmet needs, unresolved questions, logistical barriers, and communication breakdowns that persisted after healthcare encounters had concluded. Rather than viewing these situations as isolated events, many respondents described them as recurring realities within clinical practice.

A substantial number of participants reported assisting patients with navigating complex healthcare systems and administrative processes. Responses included helping patients schedule appointments, locate services, activate patient portals, complete paperwork, obtain transportation, and understand follow-up instructions. One interpreter explained that “being in the clinic where I know patients, many of them turn to me as first person to assist with many issues with the clinic” (Interpreter 23). The participant noted that many patients remained hesitant to contact healthcare organizations directly and often relied on interpreters to help connect them with appropriate resources and personnel. Another respondent described interpreters as being tasked with “facilitating bringing the LEP to the same level of understanding as a native patient” (Interpreter 109), emphasizing that this often required helping patients navigate healthcare systems in addition to language barriers.

Participants frequently described helping patients overcome logistical challenges that could affect access to care. Several respondents recounted situations involving transportation difficulties, scheduling barriers, and challenges navigating unfamiliar systems. One interpreter described remaining with a patient and her two children after an appointment to coordinate transportation home when no ride was available, ultimately making multiple phone calls and arranging transportation that should have been coordinated elsewhere in the system (Interpreter 43). Another participant described helping a patient connect with transportation resources after discovering that the family had been traveling long distances to therapy appointments through rideshare services because they lacked reliable transportation (Interpreter 34). Similar examples included helping patients understand how to obtain medications, activating patient portals, arranging follow-up appointments, and explaining hospital correspondence that patients could not understand independently (Interpreters 111, 156).

Many respondents also described identifying informational gaps that persisted after provider encounters had ended. Participants reported situations in which patients left appointments without fully understanding treatment plans, discharge instructions, medications, referrals, or next steps in their care. One interpreter explained that patients frequently approached them after appointments asking what the doctor had said, despite multiple explanations during the encounter, creating situations in which interpreters often had to reconnect patients with nurses or providers to obtain clarification (Interpreter 103). Another participant described helping patients understand how prescriptions are filled after realizing that a patient expected medications to be physically handed to them by the physician rather than sent to a pharmacy (Interpreter 105). These responses suggested that interpreters often became aware of misunderstandings that might otherwise remain unrecognized.

Participants additionally described situations in which they filled gaps created by limited staffing, unavailable resources, or fragmented care coordination. Several interpreters reported stepping into roles that were not formally assigned to them because no other staff member was available at the time. Examples included filling out forms for social work services and birth certificates during weekends when staff were unavailable (Interpreter 143), assisting patients with community resources (Interpreter 67), helping patients contact family members or outside organizations (Interpreter 93), and ensuring that patients were connected with appropriate personnel who could answer questions or address concerns (Interpreter 62). In many cases, participants described these actions as responses to immediate needs rather than intentional role expansion.

Another recurring pattern involved interpreters developing long-term relationships with patients and families that increased their awareness of barriers to care. Participants working in clinics, rehabilitation settings, oncology, and inpatient environments described repeated interactions with the same patients over time, allowing them to observe patterns that might not be visible during a single encounter. One interpreter explained, “I work in a clinic where I got to know majority of our patients and they consider me not only as interpreter but also a culturally close person that can understand their distress” (Interpreter 23). Others noted that repeated contact often positioned interpreters to recognize ongoing challenges related to access, continuity of care, patient understanding, and healthcare navigation.

Several participants explicitly framed these activities as efforts to help patients successfully access and utilize healthcare services rather than simply facilitating communication. One respondent described helping a patient who could not read or write navigate a referral to a clinic closer to home (Interpreter 152). Others described assisting with follow-up appointments,

laboratory results, insurance-related questions, and communication with schools, social service agencies, and community organizations (Interpreters 48, 67, 118). These examples reflected the perception that language barriers frequently intersected with broader systemic and administrative challenges.

Overall, participants described regularly encountering situations in which language access alone was insufficient to ensure that patients successfully navigated healthcare systems. Responses suggested that interpreters often served as informal navigators, connectors, and facilitators who helped patients overcome practical barriers to care, obtain needed information, and access available services. Across many accounts, participants portrayed these activities as a response to recurring gaps within healthcare systems rather than as isolated exceptions to the interpreter role.

Advocacy, Patient Safety, and Preventing Harm

Participants frequently described situations in which they believed their observations, interventions, or actions contributed directly to patient safety, informed decision-making, or the prevention of harm. Across responses, interpreters portrayed themselves as uniquely positioned to recognize misunderstandings, communication breakdowns, cultural barriers, and safety concerns that might otherwise go unnoticed during healthcare encounters. While participants varied in how they viewed the interpreter's role in such situations, many described intervening when they believed patient wellbeing was at risk.

Several respondents shared examples involving immediate threats to patient safety. One interpreter described stopping "a pediatric patient from running out of the door into the parking lot with cars passing through" after the child slipped away from a parent during a medical visit

(Interpreter 69). Another participant recalled identifying a potential safety issue when a patient with a pacemaker was preparing for an MRI procedure, prompting clarification that helped avoid a potentially dangerous situation (Interpreter 71). One interpreter recounted noticing that a patient was scheduled for imaging of an organ that had previously been removed and alerted staff to verify the patient's medical history. The interpreter explained that the intervention prevented an unnecessary procedure, reduced costs, and avoided unnecessary radiation exposure (Interpreter 30). Participants frequently described these actions as responses to immediate concerns rather than deliberate efforts to expand their professional role.

A second pattern involved protecting patient understanding and informed decision-making. Many interpreters described situations in which they became concerned that patients appeared confused, overwhelmed, intimidated, or unable to fully understand the information being presented. One participant recounted an encounter in which a patient appeared to be consenting to an amputation without understanding what the procedure actually involved. The interpreter explained that they alerted the healthcare team because it seemed that providers were using the word "amputation" without confirming that the patient understood its meaning (Interpreter 133). Another respondent described a situation involving a parent who appeared disengaged during a complex consent process for a lifesaving medical device. After the interpreter raised concerns, the healthcare team discovered that the parent could not read or write and did not fully understand the information being presented. The consent process was paused until additional support could be provided and understanding could be confirmed (Interpreter 139).

Participants also described helping identify communication breakdowns that providers had not immediately recognized. One interpreter explained that part of the role involves

"flagging misunderstandings" when they occur (Interpreter 17). Others described paying close attention to body language, tone, hesitation, and patient responses to determine whether information was truly being understood. Several respondents viewed this type of monitoring as an important safeguard against misunderstandings that could affect patient care, treatment decisions, or informed consent.

Advocacy and protection of patient rights also emerged as important aspects of this theme. Participants shared examples of speaking up when they believed patients were being treated unfairly, excluded from decision-making, or placed at a disadvantage because of language barriers. One interpreter described intervening during an encounter in which a provider was "being blatantly racist," questioning why a patient's Social Security number was relevant to a workers' compensation ultrasound after observing discriminatory treatment during the interaction (Interpreter 157). Another participant described advocating for a parent whose child was receiving treatment without adequate parental involvement, an incident that ultimately contributed to policy changes regarding parental participation in care (Interpreter 129). Other respondents described reporting concerns related to patient restraints, helping connect patients with social work or spiritual care services, and advocating for resources that patients may not have otherwise received (Interpreters 134, 156).

Several interpreters also described situations in which they acted to ensure that patient preferences, values, or wishes were accurately understood. One participant recalled an end-of-life case in which a family's statement that they wanted "no tubes" was initially interpreted by the healthcare team differently than the family intended. Because the interpreter understood both the cultural context and the family's explanation, additional clarification helped prevent a potentially significant misunderstanding regarding treatment preferences (Interpreter 139).

Others described advocating for children, families, and vulnerable patients when they believed important information was being overlooked or misunderstood.

Although many respondents described interventions that promoted patient safety and wellbeing, participants also acknowledged the complexity of these situations. Several recognized that efforts to protect patients could create tension with professional expectations regarding neutrality and role boundaries. One interpreter explained, “I opt for the core value of beneficence above all. But I do feel conflict between beneficence and communicative autonomy” (Interpreter 24). Another participant described ethical decision-making as weighing “the lesser of two evils” when deciding whether intervention was necessary to prevent harm or distress (Interpreter 5). These responses reflected the reality that advocacy and patient safety concerns were often intertwined with broader questions about professional boundaries and ethical responsibility.

Overall, participants described advocacy and patient safety as recurring aspects of healthcare interpreting rather than isolated events. Responses suggested that interpreters frequently viewed themselves as important safeguards within healthcare encounters, particularly when communication barriers, cultural differences, incomplete understanding, or systemic inequities placed patients at increased risk. Across many accounts, participants portrayed their interventions as efforts to protect patient wellbeing, preserve informed decision-making, and prevent avoidable harm.

Expanded Professional Identity and Team Integration

Discussions of professional identity revealed that many interpreters viewed their work as substantially broader than language transfer alone. Across responses, interpreters described functioning as communication specialists, language access experts, educators, cultural resources,

and collaborative partners within healthcare environments. For many participants, the role had evolved beyond facilitating conversations to include responsibilities that contributed to patient care, provider communication, and organizational language access efforts.

For a number of respondents, healthcare interpreting was inseparable from participation in the larger care team. Rather than viewing themselves as external service providers, these interpreters described becoming trusted members of interdisciplinary teams through repeated interactions with patients, providers, and staff. One participant stated that "the interpreter should be considered an important part of the care team by all parties" (Interpreter 72). Another argued that interpreters "should be part of the care team whenever possible," noting that interpreters often possess knowledge and perspectives that complement the expertise of other healthcare professionals (Interpreter 67). Similarly, Interpreter 127 described the profession as "faithfully rendering the message AND serving as part of the patient's care team."

Examples of this integration appeared in both routine clinical activities and broader organizational responsibilities. Some participants described rounding on patients, facilitating communication between patients and providers, supporting discharge processes, and serving as a consistent point of contact throughout a patient's healthcare journey. One interpreter explained that they routinely check whether patients have received updates from their providers and help reconnect patients with clinicians when additional communication is needed (Interpreter 2). Others reported assisting with meal rounds, providing directions to laboratories and pharmacies, and helping ensure that patients remained connected to the appropriate members of their healthcare team (Interpreters 106, 110). These experiences reflected a perception that interpreters often contribute to continuity of care in ways that extend beyond individual interpreted encounters.

Beyond their work with patients, interpreters frequently positioned themselves as subject matter experts on language access and cross-cultural communication. Many respondents described educating healthcare professionals about interpreter utilization, language access procedures, and effective communication with LEP patients. One participant explained that they train providers on "how to work with interpreters, how to access language access in our hospital, [and] the importance of language access" (Interpreter 2). Another identified "aiding medical staff in understanding linguistic competence of clients" as an important component of the interpreter role (Interpreter 51). These responses suggested that interpreters often viewed themselves as contributors to organizational language access efforts rather than solely as participants in individual patient encounters.

The responses further highlighted the specialized knowledge interpreters bring to healthcare settings. Participants described advising providers when communication strategies were ineffective, recognizing when patients appeared confused despite verbal agreement, and identifying circumstances in which language barriers were being underestimated. One interpreter recalled intervening during a complex oncology encounter when providers assumed a patient understood sufficient English to navigate the discussion independently, ultimately helping ensure that interpretation services were appropriately utilized throughout the appointment (Interpreter 5). Others described educating providers about cultural considerations, literacy concerns, and communication approaches that could improve patient understanding and engagement (Interpreters 76, 91).

When asked what responsibilities should be included in a medical interpreter's role, several respondents articulated a vision of the profession that extended beyond traditional conduit models. One interpreter identified the role as including both "cultural broker and system

navigator" responsibilities (Interpreter 4). Another stated that "a professional medical interpreter's role extends far beyond basic interpretation" and serves as a bridge for safety, understanding, and equitable care (Interpreter 56). Others emphasized collaboration with social workers, care teams, and community resources as important components of supporting patients effectively (Interpreter 130).

At the same time, participants acknowledged that interpreter expertise was not always fully recognized within healthcare organizations. While some respondents described working in environments where interpreters were respected as valued members of the care team, others expressed frustration that the complexity of their work often remained invisible. One participant noted that interpreters are expected to manage tone, pacing, cultural nuance, emotional dynamics, and communication flow while remaining largely unseen within healthcare interactions (Interpreter 136). Another expressed a desire for greater opportunities to speak up when interpreters themselves experience disrespect or marginalization in healthcare settings (Interpreter 121).

Taken together, these responses reflected an expanded view of healthcare interpreting as a profession grounded in collaboration, expertise, and active participation in healthcare delivery. Participants frequently described themselves as educators, consultants, communication specialists, and team members whose contributions extended well beyond language transfer. Across many accounts, interpreters portrayed their work as an integral component of patient-centered care and effective healthcare communication.

Upon reviewing all the qualitative medical interpreter findings, these six themes illustrate the multifaceted nature of healthcare interpreters' experiences and perceptions regarding their roles within healthcare encounters. Participants described responsibilities that extended beyond

language transfer alone, including providing human-centered care, navigating ethical tensions, facilitating culturally responsive communication, helping patients overcome barriers within healthcare systems, advocating for patient safety, and contributing as collaborative members of healthcare teams. While perspectives differed regarding the appropriate scope of interpreter involvement, the responses collectively highlighted the complex and evolving nature of healthcare interpreting practice.

The following section presents findings from healthcare providers. Provider responses offer an additional perspective on interpreters' roles within healthcare settings, including perceptions of interpreter involvement, professional boundaries, patient support, communication, and contributions to patient care.

Healthcare Provider Findings

This section presents the findings from the healthcare provider survey portion of the study. The quantitative results offer insight into how healthcare providers perceive the role of medical interpreters within clinical settings, particularly in relation to activities that extend beyond direct language interpreting. These findings explore provider perspectives on interpreter involvement in emotional support, cultural mediation, patient advocacy, and interdisciplinary collaboration.

The section begins with descriptive quantitative findings related to provider demographics, experiences working with interpreters, and perceptions of interpreter roles and contributions to patient care. Selected figures are included to highlight key trends and areas of strong consensus among participants. The quantitative findings are followed by a qualitative analysis examining

providers' open-ended responses regarding interpreter collaboration, emotional support, professional boundaries, and recommendations for improving interpreter services.

Quantitative Findings

Participant Demographics and Professional Background

A total of 19 healthcare providers completed the healthcare provider survey. Participants represented a range of healthcare professions, clinical specialties, and healthcare settings.

The sample was primarily composed of physicians (n = 12, 63.2%), followed by nurse practitioners (n = 2, 10.5%) and nurses (n = 2, 10.5%). Additional respondents included a social worker, community health worker, clinical nurse specialist, and speech-language pathologist (n = 1 each, 5.3%).

Healthcare providers reported working in a variety of healthcare settings. Hospitals were the most reported primary work setting (n = 8, 42.1%), followed closely by outpatient clinics (n = 7, 36.8%). Additional participants reported working in emergency departments (n = 3, 15.8%) and other healthcare settings (n = 1, 5.3%).

Participants represented multiple age groups, with the largest proportion falling within the 40–49 age range (n = 10, 52.6%), followed by 50–59 years (n = 5, 26.3%) and 60 years or older (n = 3, 15.8%). One participant was between 30–39 years old (5.3%). No participants reported being between 18–29 years old.

Most participants identified as female (n = 14, 73.7%), while five participants identified as male (26.3%).

Participants represented a variety of specialty areas. Pediatrics was the most frequently reported specialty (n = 5, 26.3%), followed by emergency medicine (n = 3, 15.8%). Primary care/family medicine, surgery, and obstetrics and gynecology were each reported by two participants (10.5% each). Internal medicine, reproductive health, chaplaincy/spiritual care, pediatric intensive care, and speech-language pathology were each represented by one participant (5.3%).

Experience Working with Medical Interpreters

Most healthcare providers in the sample reported extensive experience working with LEP patients. Seventeen participants (89.5%) indicated having 13 or more years of experience working with LEP patient populations. One participant reported 8–12 years of experience (5.3%), and one participant reported 1–3 years of experience (5.3%). No participants reported 4–7 years of experience.

Providers also reported frequent collaboration with medical interpreters in clinical practice. Weekly interaction with interpreters was the most reported frequency (n = 7, 36.8%), followed by daily interaction (n = 6, 31.6%) and several times per week (n = 4, 21.1%). Two participants (10.5%) reported working with interpreters monthly.

Participants reported utilizing multiple interpreting modalities in clinical care. In-person interpreting was the most reported primary modality, although many providers indicated using a combination of in-person interpreters, video remote interpreting (VRI), and over-the-phone interpreting (OPI) depending on the clinical situation and availability of services. Several respondents also reported working across all four modalities.

Institutional Requirements for Interpreters

Healthcare providers were asked about institutional requirements for different types of interpreters, including staff healthcare interpreters, third-party vendors, and ad hoc or bilingual staff serving as interpreters (see Table 4). Across all three categories, a large proportion of respondents indicated uncertainty regarding institutional requirements.

For third-party vendor interpreters, 18 participants reported they were not sure what requirements were in place. Only one participant identified national certification for spoken language interpreters as a requirement. No respondents selected 40-hour medical interpreter training, language proficiency testing, background checks, on-the-job training, or HIPAA training as known requirements for third-party interpreters.

Responses regarding staff healthcare interpreters demonstrated somewhat greater awareness of institutional standards. National certification for spoken language interpreters and language proficiency testing were each identified by six participants. Background checks were reported by five participants, HIPAA training by four participants, and 40-hour medical interpreter training by three participants. Two respondents identified on-the-job training as a requirement. However, 12 participants still reported being unsure about institutional requirements for staff interpreters.

Awareness of requirements for ad hoc or bilingual staff interpreters appeared more limited. Fourteen participants reported they were not sure what requirements existed for bilingual staff serving as interpreters. Language proficiency testing was the most frequently identified requirement (n = 5), while one participant identified national certification for spoken language interpreters and one participant identified on-the-job training. No participants selected 40-hour

interpreter training, background checks, HIPAA training, or national certification for sign language interpreters as known requirements for bilingual staff interpreters.

Table 4

Healthcare Provider Awareness of Institutional Interpreter Requirements by Interpreter Type

Type of Institutional Requirement	Staff Healthcare Interpreter	Third-Party Vendors	Ad hoc/Bilingual Staff
Not Sure	12	18	14
Language Proficiency Testing	6	0	5
Spoken Language National Certification	6	1	1
On-the-Job Training	2	0	1
ASL Certification	4	0	0
40+ Hour Training	3	0	0
Background checks	5	0	0
HIPAA Training	4	0	0

Interpreter Intervention During Healthcare Encounters

Nearly all healthcare providers reported observing interpreters step in to assist during situations involving communication difficulties or patient needs beyond direct language interpreting. Subsequent survey questions examined both the situations that appeared to trigger interpreter intervention and the specific activities providers observed interpreters performing beyond language interpretation alone.

Eleven participants (57.9%) reported observing this behavior occasionally, while seven participants (36.8%) reported observing it frequently. Only one participant (5.3%) reported never observing interpreters step in during healthcare encounters.

Providers identified several factors that appeared to trigger interpreter intervention. The most frequently selected trigger was situations in which the patient appeared confused or distressed (n = 17, 89%). Healthcare providers struggling with communication was also commonly identified (n = 16, 84%). Additional triggers included medical urgency requiring immediate response (n = 6, 32%) and challenges associated with remote video interpreting (n = 3, 16%).

When asked to rank the most common triggers for interpreter intervention, patient confusion or distress was most frequently ranked as the primary factor. Complex medical information requiring additional explanation and healthcare providers struggling with communication were also commonly ranked among the top reasons interpreters stepped in to assist. Patient requests for direct assistance from interpreters also emerged as a recurring factor in provider responses.

Tasks Beyond Interpreting

Healthcare providers were asked to identify tasks beyond interpreting that they had observed interpreters perform during healthcare encounters. Providers most frequently ranked scheduling appointments or follow-up visits as the most observed activity beyond interpreting (n = 7). Cultural explanation or mediation was also frequently identified as a primary activity (n = 5), followed by explaining medical procedures or next steps (n = 4).

When ranking the second most frequently observed activities, providers most identified explaining medical procedures or next steps (n = 5). Additional activities included providing emotional support or comfort (n = 3), cultural explanation or mediation (n = 3), advocating for patient needs (n = 2), and assisting with transportation or resource information (n = 2).

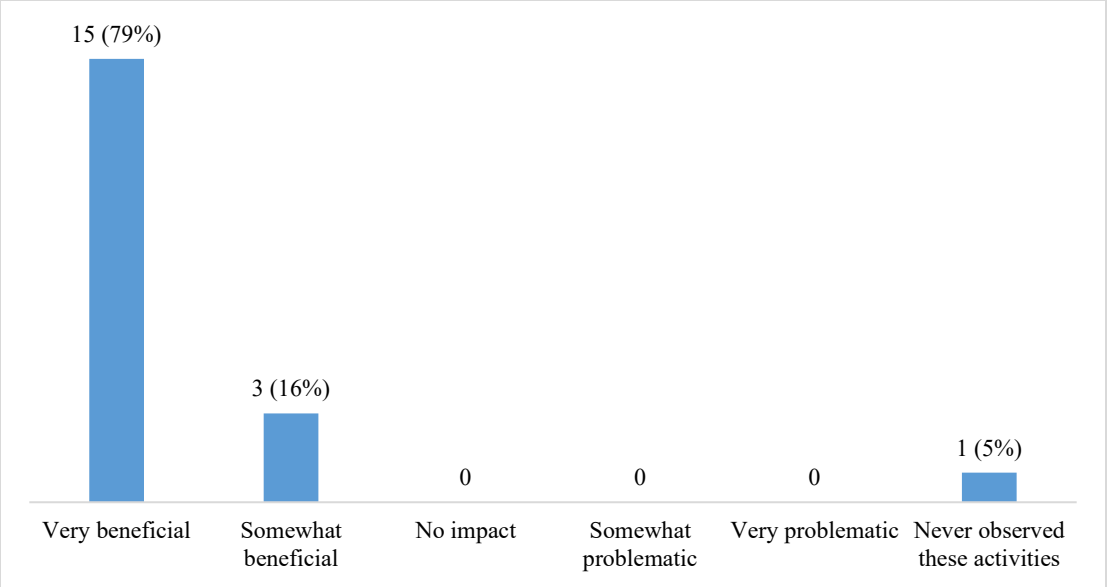
Advocating for patient needs emerged most prominently in the third most frequent ranking category (n = 9), suggesting that while advocacy may not occur as consistently as scheduling assistance or procedural explanation, providers still observed it regularly in clinical encounters. Cultural mediation, emotional support, and patient requests for assistance also continued to appear across multiple ranking categories.

Only a small number of participants reported never observing interpreters assist with tasks beyond interpreting. Overall, the findings suggest that healthcare providers observed interpreters engaging in a range of supportive, logistical, cultural, and patient-centered activities extending beyond message transfer between languages.

When providers were asked how these activities affected patient care, most respondents viewed interpreter assistance beyond interpreting positively (see Figure 22). Fifteen participants (78.9%) described these activities as very beneficial, while three participants (15.8%) described them as somewhat beneficial. No participants reported these activities as having no impact or being problematic. One participant (5.3%) indicated they had never observed interpreters engaging in these activities. These findings suggest that these healthcare providers largely perceived interpreter contributions beyond interpreting as beneficial to patient care.

Figure 22

Healthcare Provider Perceptions of Effect of Interpreter Activities Beyond Interpreting



Emotional Support, Professional Boundaries, and Interpreter Contributions

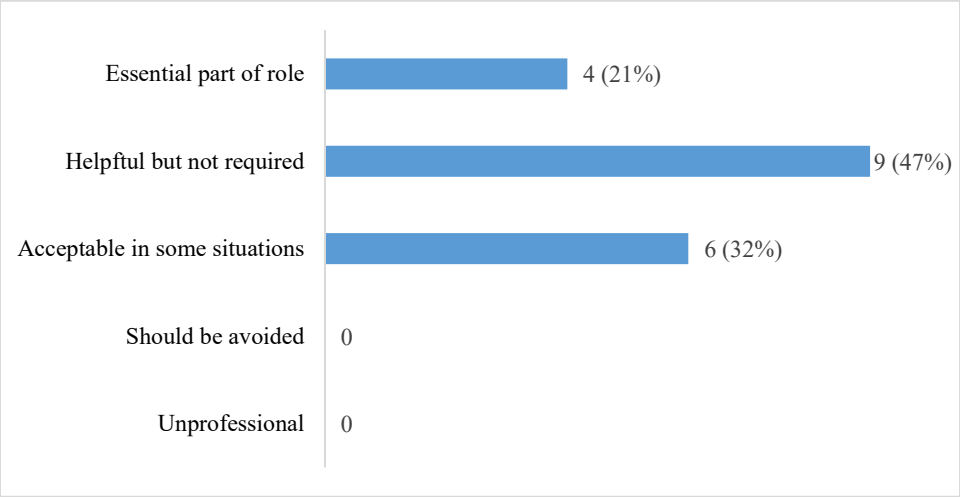
Healthcare providers generally expressed positive perceptions regarding interpreters providing assistance beyond direct language interpreting. Most participants reported feeling very comfortable with interpreters engaging in these activities (n = 13, 68.4%), while three participants (15.8%) reported feeling somewhat comfortable. Two participants (10.5%) described themselves as neutral, and no participants reported discomfort with these activities. One participant (5.3%) indicated they had never observed interpreters engaging in activities beyond interpreting.

Participants also reported regularly observing interpreters provide emotional support during difficult healthcare encounters. More than half of respondents stated they observed this occasionally (n = 10, 52.6%), while three participants (15.8%) reported observing emotional support frequently. Five participants (26.3%) indicated these situations occurred rarely, and one participant (5.3%) reported never observing them.

Provider perspectives on interpreter emotional support were largely favorable (see Figure 23). Nearly half of participants characterized emotional support as helpful but not necessarily required (n = 9, 47.4%). Six participants (31.6%) viewed emotional support as acceptable in certain situations, while four participants (21.1%) considered it an essential part of the interpreter's role. No respondents described interpreter emotional support as unprofessional or something that should be avoided.

Figure 23

Healthcare Provider Perspectives on Interpreter Emotional Support



Respondents likewise emphasized the broader importance of emotional support within healthcare interactions. Fifteen participants (78.9%) described emotional support as very important in patient care, while four participants (21.1%) considered it somewhat important. No participants selected neutral or negative response options.

When asked whether interpreters should follow the same emotional support expectations as other healthcare professionals, most respondents indicated that interpreters should provide

emotional support at a less intensive level than other members of the healthcare team (n = 12, 63.2%). Seven participants (36.8%) believed interpreters should follow the same expectations exactly. No participants supported eliminating emotional support from the interpreter role.

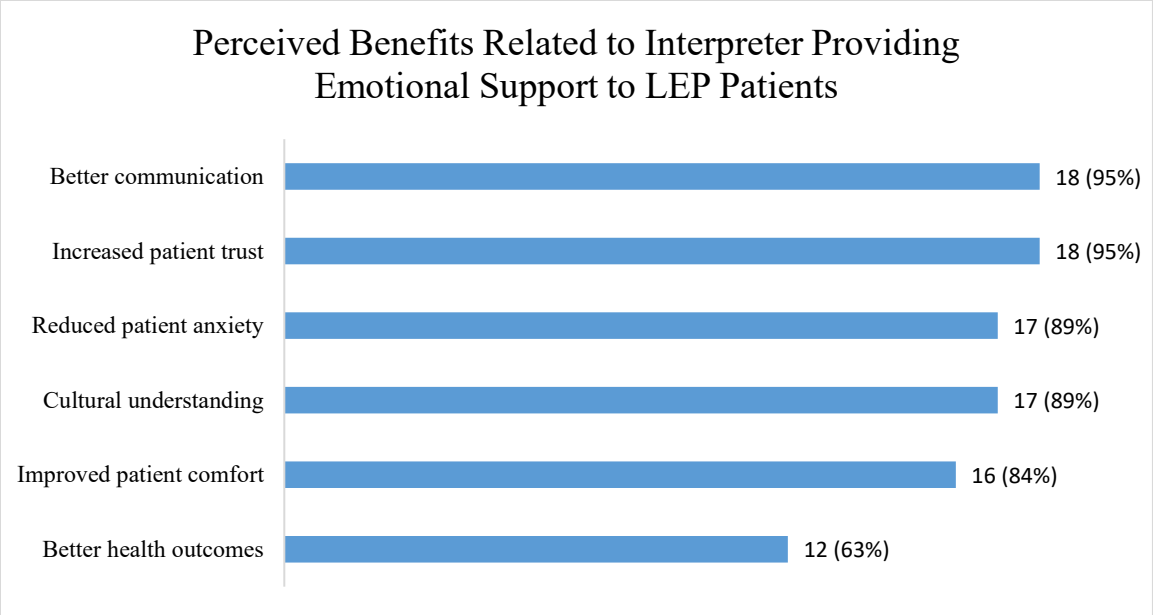
Similarly, providers largely agreed that interpreters should provide emotional support and comfort to patients. Twelve participants (63.2%) agreed with this statement, and three participants (15.8%) strongly agreed. Four participants (21.1%) reported neutral views. No respondents disagreed or strongly disagreed.

Healthcare providers identified multiple perceived benefits associated with interpreter emotional support (see Figure 24). Better communication (n = 18, 94.7%) and increased patient trust (n = 18, 94.7%) were the most frequently selected benefits. Reduced patient anxiety (n = 17, 89.5%), improved cultural understanding (n = 17, 89.5%), and improved patient comfort (n = 16, 84.2%) were also commonly identified. Additionally, 12 participants (63.2%) associated interpreter emotional support with better health outcomes.

Figure 24

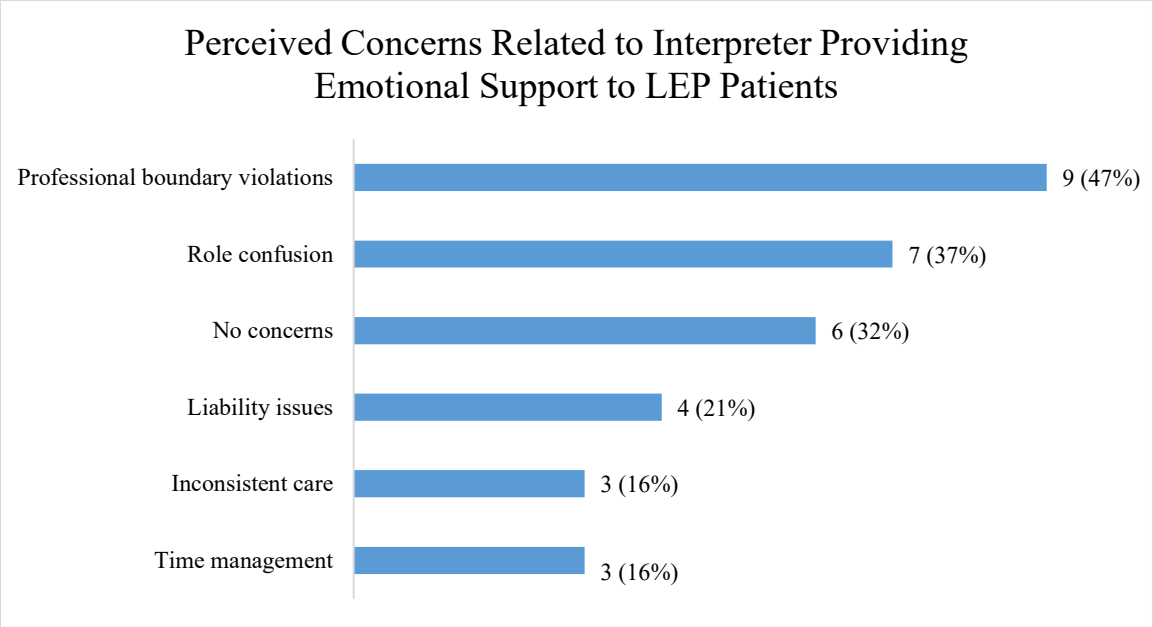
Perceived Benefits and Concerns Related to Interpreter Emotional Support

Figure 24a: Perceived Benefits Related to Interpreter Providing Emotional Support to LEP Patients



Although responses were predominantly positive, participants also identified several concerns related to interpreter emotional support and expanded role expectations. Professional boundary violations emerged as the most commonly reported concern (n = 9, 47.4%), followed by role confusion (n = 7, 36.8%). Liability issues were identified by four participants (21.1%), while inconsistent care and time management concerns were each selected by three participants (15.8%). At the same time, six participants (31.6%) reported having no concerns regarding interpreter emotional support. One respondent additionally referenced concerns related to misinformation or interference with communication between the healthcare team and patient.

Figure 24b: Perceived Concerns Related to Interpreter Providing Emotional Support to LEP Patients



Interpreter Integration Within the Healthcare Team

Responses from healthcare providers reflected a high level of interpreter integration within clinical care environments. Eight participants (42.1%) reported always including interpreters as part of the healthcare team, while seven participants (36.8%) indicated they often did so. One participant (5.3%) selected sometimes, and three participants (15.8%) reported rarely including interpreters as part of the healthcare team. No respondents selected never.

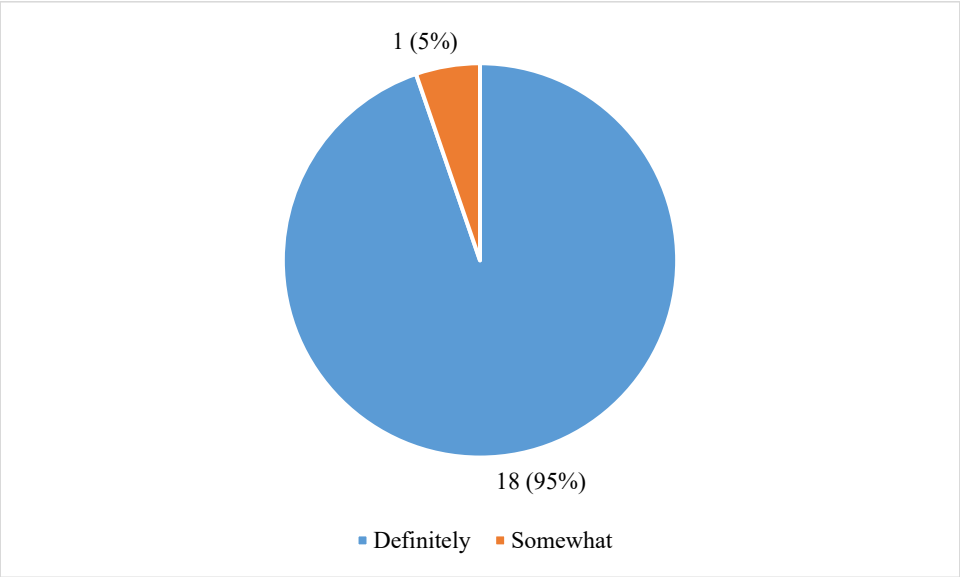
Providers also described regularly incorporating interpreters' cultural knowledge into patient care. Nearly half of participants (n = 9, 47.4%) reported often utilizing interpreters' cultural insights, while five participants (26.3%) indicated they always did so. Three participants (15.8%) selected sometimes, and none selected rarely or never. Two respondents (10.5%) stated that interpreters did not provide cultural insights within their clinical setting.

Recognition of interpreters as members of the healthcare team was especially pronounced (see Figure 25). Eighteen participants (94.7%) stated they definitely considered interpreters part

of the healthcare team, while one participant (5.3%) selected somewhat. No respondents selected neutral or negative response options.

Figure 25

Healthcare Provider Perceptions of Interpreters as Members of the Healthcare Team



Although providers generally viewed interpreters as integrated members of the care team, consultation regarding cultural considerations varied across participants. Six respondents (31.6%) reported often consulting interpreters about cultural issues, while another six participants (31.6%) indicated they sometimes did so. Five participants (26.3%) selected rarely, one participant (5.3%) selected always, and one participant (5.3%) reported never consulting interpreters regarding cultural considerations.

Participants also reported differing levels of familiarity with professional guidelines for medical interpreters. Seven providers (36.8%) described themselves as very familiar with these guidelines, while four participants (21.1%) reported being somewhat familiar. Three participants

(15.8%) identified themselves as slightly familiar, four participants (21.1%) reported not being familiar, and one participant (5.3%) stated they had never heard of professional guidelines for medical interpreters.

More than half of respondents indicated they had received some form of training related to working with interpreters or LEP patients (n = 11, 57.9%). The remaining eight participants (42.1%) reported receiving no formal training in this area. Training experiences varied and included orientation sessions (n = 7, 36.8%), cultural competency training (n = 7, 36.8%), conference workshops (n = 6, 31.6%), online modules (n = 5, 26.3%), and in-service training (n = 4, 21.1%). Several participants also referenced educational lectures involving interpreters or language access topics.

Interest in additional education related to interpreter collaboration and LEP patient care was mixed. Eight participants (42.1%) expressed interest in receiving additional training, seven participants (36.8%) reported no interest, and four participants (21.1%) indicated they were unsure.

Qualitative Findings

The healthcare provider questionnaire included five open-ended questions designed to further explore providers' experiences working with medical interpreters and their perceptions of interpreter roles beyond message transfer skills. These questions invited participants to describe examples of emotional support provided by interpreters, challenges related to interpreter involvement beyond language interpretation, recommendations for improving collaboration, and perspectives on interpreter services within healthcare settings.

Provider responses offered additional context and nuance beyond the quantitative findings, particularly regarding emotional support, interpreter integration within the healthcare team, modality differences between in-person and remote interpreting, and perceptions of professional boundaries. Several recurring patterns emerged across responses, revealing both strong appreciation for interpreters' contributions and concerns related to institutional limitations, communication challenges, and evolving models of interpreter service delivery. To protect participant anonymity, healthcare provider responses are identified numerically throughout the qualitative findings section (e.g., Provider 1, Provider 2).

The following themes reflect the most prominent patterns identified throughout the provider responses.

Interpreters as Providers of Human Connection and Compassion

Healthcare providers frequently described interpreters as offering emotional support and human connection to LEP patients during vulnerable healthcare encounters. Responses suggested that providers often viewed these interactions as beneficial to patient care, particularly during emotionally difficult situations involving fear, isolation, distress, or serious medical discussions. Several participants described interpreters comforting patients, offering reassurance, or helping patients feel less alone during healthcare encounters.

One provider described a situation in which a "father and husband had left his family and the interpreter provided personal words of support to the mother and child" (Provider 1). Another participant recalled an interpreter assisting a worried parent by "provid[ing] emotional support and reassurance," reviewing pharmacy directions in the patient's language, and ensuring follow-up care was arranged (Provider 4). Other providers referenced interpreters offering condolences

during end-of-life discussions, staying emotionally present during goals-of-care conversations, and reassuring patients after difficult diagnoses. One provider noted that interpreters would sometimes explain "that a condition is common and other patients have had similar news" (Provider 17).

Many providers framed emotional support as consistent with compassionate, patient-centered healthcare rather than as inappropriate role expansion. One participant stated, "It is part of being human and being in a care-giving profession" (Provider 4). Similarly, another provider described compassionate support as "a core value of Mayo [Clinic] practice" and emphasized that "it should be encouraged for anyone in any situation" (Provider 18). Several providers also connected emotional support to the trust interpreters develop with patients over time. One participant explained that interpreters "create a trust with the patient, so emotional support would be welcomed" (Provider 10), while another observed that "the interpreter often knows the patient better and it's clear that the patient feels comforted by their presence" (Provider 11).

In-Person Interpreters as Relational and Clinical Assets

A recurring theme throughout the provider responses involved clear distinctions between in-person interpreter services and remote modalities such as video remote interpreting (VRI) and over-the-phone interpreting (OPI). While providers acknowledged the practicality and accessibility of remote interpreting, many participants described in-person interpreters as offering advantages that extended beyond direct language interpretation alone. Responses frequently referenced stronger communication flow, greater patient comfort, continuity of care, and more collaborative interactions between providers, patients, and interpreters when interpreters were physically present.

Several providers specifically associated in-person interpreting with higher quality patient interactions and fewer communication barriers. One participant commented that "in person interpreters provide a level of care that is superior to those by phone or video," citing "background noises, distractions and poor audio or video quality" as ongoing concerns with remote services (Provider 1). Another provider emphasized that additional provider education was not the primary issue, stating instead, "I don't need training. I need resources - in person interpreters on demand. VRIs that work. Internet access that doesn't cut" (Provider 16). Concerns regarding audio quality and accessibility for elderly or cognitively impaired patients were also noted repeatedly throughout the responses.

Providers additionally connected in-person interpreting with trust, familiarity, and continuity in patient care. One participant explained that patients within their clinic were "much more comfortable with in person, staff interpreters" who were often known to patients outside of the healthcare setting (Provider 9). Another provider observed that continuity "helps the flow" when interpreters are both trusted and clinically experienced (Provider 7). These responses frequently suggested that interpreters who maintain ongoing relationships with patients may contribute to a greater sense of comfort and stability during healthcare encounters, particularly during emotionally complex conversations.

Some participants also expressed frustration regarding institutional shifts away from in-person interpreter services. One provider described previously working alongside "amazing in-person interpreters" who played an important role during dementia care, goals-of-care discussions, and emotionally difficult encounters (Provider 16). The participant went on to describe how the institution later reduced in-person interpreter availability in favor of VRI and OPI services viewed as "good enough" from a budgetary perspective (Provider 16). Another

provider stated simply, “I miss the days of having an in-person interpreter” (Provider 10). Although providers generally recognized the importance of remote modalities for expanding access, multiple responses reflected concern that increasing reliance on remote interpreting may reduce opportunities for continuity, relationship-building, and emotionally supportive care for LEP patients.

Interpreters as Integrated Members of the Healthcare Team

Another prominent theme involved healthcare providers describing interpreters as active contributors to patient care rather than passive language conduits. Multiple responses emphasized the importance of collaboration between interpreters and healthcare professionals, particularly in situations involving cultural considerations, communication barriers, or complex care discussions. Providers frequently characterized interpreters as knowledgeable guides whose insights could strengthen communication and improve care delivery for LEP patients.

Several participants specifically referenced the value of interpreter expertise within clinical interactions. One provider stated, “I would very much want to hear from the interpreter to know more of what they have for recommendations with their expertise as a guide” (Provider 19). Another participant emphasized the need to “stress advocacy” as part of the interpreter role (Provider 2). Responses also highlighted the importance of communication between departments and service lines, with one provider recommending greater inclusion of interpreters within the healthcare team and improved coordination surrounding LEP patient care (Provider 5).

Providers additionally discussed the importance of collaborative practices and interprofessional education. One participant referenced best practices for working with interpreters, including maintaining eye contact with the patient, speaking in the first person, and

improving provider understanding of interpreter collaboration during healthcare encounters (Provider 10). The same provider advocated for interpreter education and professional societies to continue promoting interprofessional collaboration and training related to the care of LEP patients.

Several responses also reflected frustration with attitudes that minimized the role of interpreters within healthcare settings. One participant specifically noted the need for provider training to reduce assumptions that speaking "enough" of another language eliminates the need for professional interpreter services (Provider 5). Another provider emphasized that interpreters "need to be seen as active member[s] of the care team not as tools" (Provider 2). Similarly, one participant described interpreters as "a critical part of the healthcare team," emphasizing that interpreters are "not just language conduit robots, but humans who play a role in ensuring safe and equitable care for LEP patients and families" (Provider 15).

Professional Boundaries and Appropriate Emotional Support

Although healthcare providers generally described interpreter emotional support positively, several participants also referenced the importance of maintaining appropriate professional boundaries within healthcare encounters. Responses suggested that providers viewed emotional support as acceptable in many situations, while also recognizing that the type and extent of support may vary depending on professional role, training, and clinical circumstances.

One chaplain explained that emotional support is an important component of healthcare broadly, but noted differences in professional responsibilities across disciplines. The participant stated that chaplains are specifically trained to provide "deeper emotional/spiritual support,"

while interpreters primarily assist through communication and interpretation during emotionally difficult situations (Provider 5). At the same time, the provider acknowledged that interpreters may provide additional support when other members of the care team are unavailable.

A small number of responses also referenced concerns related to role boundaries or excessive involvement. One provider described "some boundary issues" involving interpreters who worked closely with patient services staff, although the participant still emphasized the overall value of the interpreter team within patient care (Provider 16). Another participant noted having "only a handful of bad experiences" involving interpreters who were described as "invasive" or unwilling to accept feedback intended to improve communication flow and efficiency during healthcare encounters (Provider 1).

At the same time, many providers continued to frame compassionate support as appropriate within the context of patient-centered care. One participant stated that "providing emotional support to another person in a time of need is a kindness" and described compassion as "a core value" within healthcare practice (Provider 18). Another provider explained that emotional support from interpreters was often welcomed because "they create a trust with the patient" (Provider 10).

Institutional Barriers and Resource Limitations

In addition to describing positive experiences with interpreters, several providers also referenced institutional and logistical barriers that affected interpreter services within healthcare settings. Responses frequently mentioned staffing limitations, inconsistent technology, communication challenges, and reduced access to in-person interpreters.

Some providers expressed frustration regarding the increasing reliance on remote interpreting modalities in situations where they felt in-person services would be more beneficial. One participant described working in a healthcare system that gradually reduced in-person interpreter staffing despite previously positive experiences with those interpreters during dementia care, goals-of-care discussions, and emotionally difficult conversations (Provider 16). The provider noted that institutional leadership viewed VRI and OPI services as "good enough" alternatives despite ongoing concerns regarding care quality and patient experience.

Technology-related concerns also appeared throughout the responses. One participant referenced challenges involving "background noises, distractions and poor audio or video quality" during remote interpreting encounters (Provider 1). Another provider emphasized the need for reliable equipment and improved technological support, including functioning VRIs, stable internet access, and headphones for elderly patients with hearing or cognitive difficulties (Provider 16).

Several providers additionally highlighted workflow and communication barriers involving interpreter services. One participant emphasized the importance of "communication between the various service lines" and improved inclusion of interpreters within care coordination processes (Provider 5). Another response stressed the need for more consistency across telephone and video interpreter services to better support providers and LEP patients during healthcare encounters (Provider 1).

Spanish-Speaking LEP Patient Findings

The patient survey provides an opportunity to examine interpreter services from the perspective of the individuals most directly affected by language access in healthcare settings.

Responses offer insight into how Spanish-speaking LEP patients experience interpreter-mediated encounters, what they expect from interpreters, and how they perceive interpreter involvement in communication, emotional support, cultural understanding, and healthcare navigation.

The findings begin with an overview of participant characteristics and experiences using interpreter services across different healthcare settings and modalities. Subsequent sections explore patient perceptions of interpreter assistance beyond language interpretation, the role of emotional support and cultural connection during healthcare encounters, interpreter integration within the healthcare team, and overall satisfaction with interpreter services. The chapter concludes with a thematic analysis of patients' open-ended responses, highlighting the experiences, concerns, and recommendations shared by participants in their own words.

Quantitative Findings

The following section presents the quantitative findings from the Spanish-speaking LEP patient survey. In total, 15 participants completed the questionnaire regarding their experiences receiving healthcare services with professional medical interpreters. The survey explored patient perspectives on interpreter roles, emotional support, cultural understanding, communication, and activities beyond direct language interpretation. Quantitative findings are presented first to provide an overview of participant experiences and perceptions before exploring qualitative responses in later sections.

Spanish-Speaking LEP Patient Demographics

Among the 15 Spanish-speaking LEP patient participants, the largest age group represented was 40–49 years old (60%, n = 9), followed by participants between 30–39 years old

(26.7%, n = 4). Smaller representation was observed among participants ages 50–59 (6.7%, n = 1) and 60 or older (6.7%, n = 1). No participants reported being between 18–29 years old. The patient sample was primarily female (80%, n = 12), while 20% (n = 3) identified as male. All participants identified Spanish as their preferred language for healthcare communication (100%, n = 15).

Participants represented a range of time living in the United States. The largest group reported living in the United States for more than 20 years (40%, n = 6), followed by 6–10 years (33.3%, n = 5). Smaller groups reported living in the United States for 1–5 years (13.3%, n = 2) and 11–20 years (13.3%, n = 2). No participants reported living in the United States for less than one year or being born in the United States.

Educational backgrounds varied among participants, although most reported lower to moderate levels of formal education. High school diploma or GED completion was the most frequently reported education level (40%, n = 6), followed by some college education (26.7%, n = 4). Two participants reported some high school education (13.3%, n = 2), one participant reported completing elementary school only (6.7%, n = 1), and one participant reported holding a bachelor's degree (6.7%, n = 1). One participant preferred not to answer the education question (6.7%, n = 1).

Experience Working with Interpreters

Most participants reported receiving interpreter services on a regular basis. Forty percent (n = 6) indicated they received interpreter services frequently, defined as weekly or more, while another 40% (n = 6) reported receiving services regularly on a monthly basis. Smaller groups reported using interpreter services occasionally a few times per year (13.3%, n = 2) or for the

first time (6.7%, n = 1). These findings suggest that most participants had repeated exposure to professional interpreter services and ongoing experience navigating healthcare encounters with language assistance.

Participants also reported receiving healthcare services across a variety of medical specialties and care settings. Primary care was the most frequently reported specialty area visited by participants (86.7%, n = 13), followed by pediatrics (53.3%, n = 8), surgery (33.3%, n = 5), and mental or behavioral health services (26.7%, n = 4). Smaller numbers of participants reported visits involving the emergency department (13.3%, n = 2), internal medicine (6.7%, n = 1), and other specialty areas (13.3%, n = 2). No participants reported cardiology as a commonly visited specialty area. These findings suggest that participants interacted with interpreter services across a broad range of healthcare environments, including both routine and high-stakes medical encounters.

Participants also reported exposure to multiple interpreting modalities. Video Remote Interpreting (VRI) was the most commonly reported service type, used by 86.7% of participants (n = 13), followed closely by in-person interpreters (80%, n = 12). Over-the-phone interpreting (OPI) services were reported by 53.3% of participants (n = 8), while 40% (n = 6) indicated they had received assistance from bilingual staff members. Many participants reported receiving care through multiple interpreting modalities rather than relying on a single service format.

When asked about their primary interpreting modality, in-person interpreting emerged as the most common primary service type. Eleven participants primarily relied on in-person interpreters, compared to three participants who primarily used VRI services and one participant who primarily relied on OPI services. Several participants reported combinations of modalities

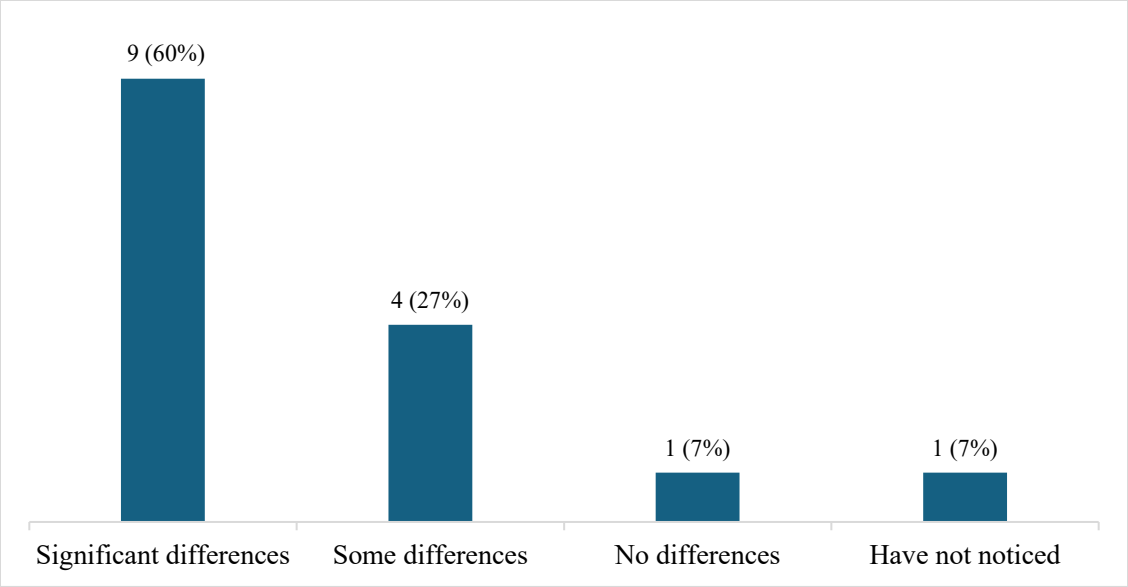
depending on the healthcare setting or circumstance, suggesting that interpreter service delivery was often fluid rather than limited to a single format.

Patients also reported continued involvement of family members in healthcare communication despite access to professional interpreter services. Forty percent of participants (n = 6) stated family members never interpreted during medical visits, while 33.3% (n = 5) reported this occurred rarely. However, 26.7% (n = 4) indicated family members sometimes interpreted during healthcare encounters. No participants reported family members often or always serving in this role.

Differences between interpreting modalities were strongly recognized by participants (see Figure 26). Sixty percent (n = 9) reported noticing significant differences in how interpreters could assist them depending on whether services were provided in person, through video, or by phone. Another 26.7% (n = 4) reported noticing some differences. Only one participant reported no noticeable differences between modalities, while one participant stated they had not noticed differences.

Figure 26

Perceived Differences in Interpreter Support Across Modalities



Knowledge regarding interpreter certification and training appeared limited among participants. More than half of respondents (53.3%, n = 8) reported they did not know whether their interpreter held certification or specialized medical interpreter training. Three participants (20%, n = 3) believed their interpreters had certification, while two participants (13.3%, n = 2) reported their interpreters had special training. One participant believed their interpreter did not have formal credentials or training (6.7%, n = 1), and another participant reported never thinking to ask about interpreter qualifications (6.7%, n = 1).

Tasks Beyond Interpreting

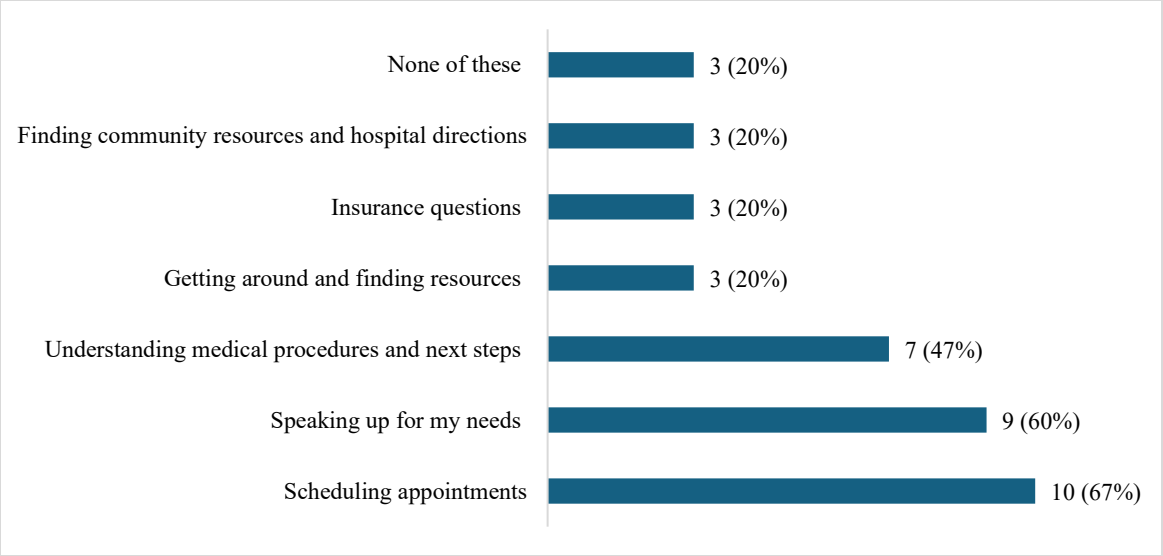
Patient responses indicated that interpreters frequently became involved in healthcare encounters in ways that extended beyond direct language interpretation. When communication difficulties arose, participants most commonly reported interpreters stepping in when complex medical information required additional explanation (60%, n = 9). Many participants also described interpreters intervening immediately after recognizing communication problems (40%,

n = 6) or when patients appeared upset, overwhelmed, or confused (33.3%, n = 5). Other participants indicated interpreters became more involved after providers attempted communication multiple times (26.7%, n = 4) or waited for permission before assisting further (26.7%, n = 4). A smaller number of participants reported interpreters stepping in when cultural differences appeared to affect understanding (13.3%, n = 2). Only one participant stated that interpreters never became involved during communication difficulties (6.7%, n = 1).

Participants also reported interpreters assisting directly with practical and supportive tasks beyond interpreting conversations. As shown in Figure 27, scheduling appointments was the most frequently reported activity (66.7%, n = 10), followed by interpreters speaking up for patient needs (60%, n = 9). Nearly half of participants indicated interpreters assisted them in understanding medical procedures and next steps in care (46.7%, n = 7). Additional forms of assistance included helping patients navigate healthcare systems and resources (20%, n = 3), addressing insurance-related questions (20%, n = 3), and providing information about community resources or directions within healthcare facilities (20%, n = 3). Three participants reported their interpreters did not assist with tasks beyond direct interpretation (20%, n = 3).

Figure 27

Patient-Reported Interpreter Assistance Beyond Language Interpretation



Overall, these forms of assistance were viewed positively by participants. More than half described the support they received as very useful (53.3%, n = 8), while another 20% (n = 3) considered it extremely useful. Only one participant rated the assistance as somewhat useful (6.7%, n = 1), and no participants characterized these additional forms of interpreter involvement as not useful. Three participants indicated their interpreters had never provided assistance beyond interpreting tasks (20%, n = 3).

Emotional Support and Interpreter Role Expectations

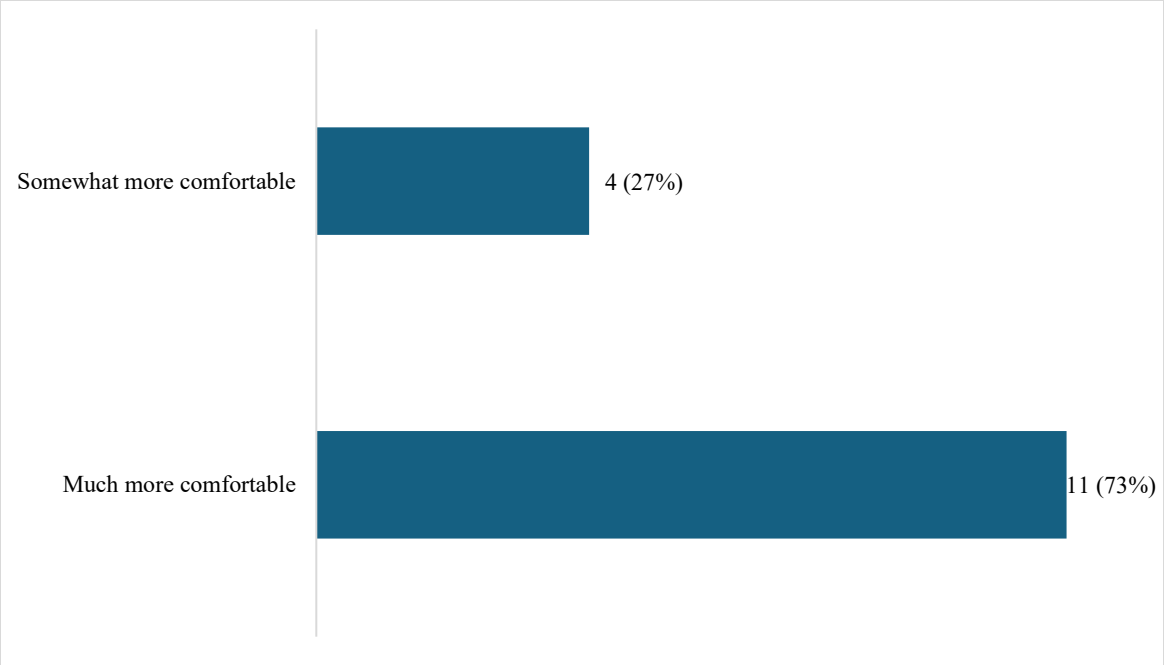
Participants reported a range of experiences related to emotional support provided by interpreters during healthcare encounters. Approximately one-quarter of participants stated interpreters provided emotional support "a lot" (26.7%, n = 4), while 20% (n = 3) reported receiving some emotional support. One participant indicated receiving a little emotional support (6.7%, n = 1). In contrast, 26.7% (n = 4) reported interpreters did not provide emotional support, while 20% (n = 3) were unsure whether the support they received could be characterized as emotional support.

When participants described how interpreters provided comfort or support, several themes emerged. The most frequently reported forms of support included interpreters speaking in a caring manner in the patient's own language (33.3%, n = 5), helping patients feel less alone during healthcare encounters (33.3%, n = 5), explaining information in ways that made cultural sense (33.3%, n = 5), and helping patients feel calmer when worried (33.3%, n = 5). Some participants also reported interpreters remaining with them during painful or frightening procedures (26.7%, n = 4). A smaller number of participants stated interpreters made them feel understood through shared cultural or linguistic backgrounds (13.3%, n = 2). Seven participants selected "not applicable" for this question (46.7%, n = 7).

As shown in Figure 28, participants overwhelmingly reported increased comfort when interpreters spoke their preferred language. Most participants indicated feeling much more comfortable when communicating through an interpreter who spoke their language (73.3%, n = 11), while the remaining participants reported feeling somewhat more comfortable (26.7%, n = 4). No participants reported feeling less comfortable when interpreters spoke their preferred language.

Figure 28

Patient Comfort Levels When an Interpreter Was Present

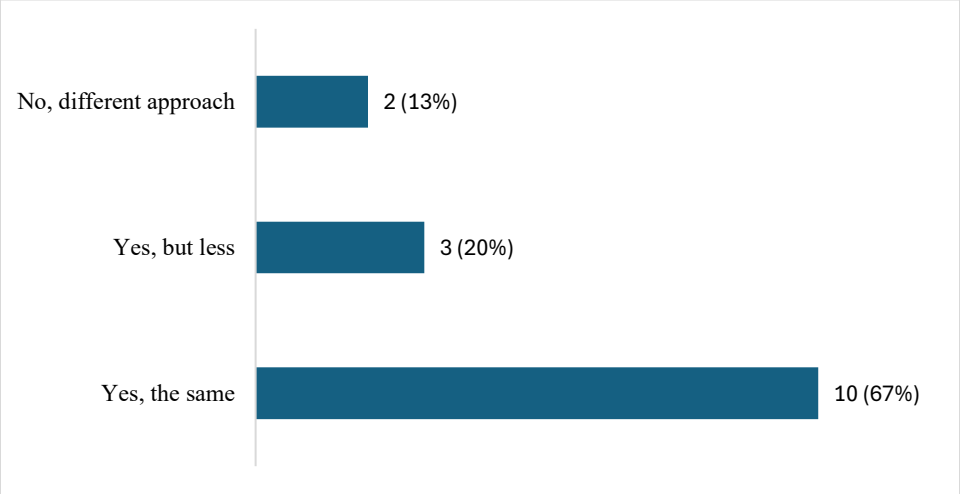


Participants also placed high importance on emotional support within healthcare settings more broadly. Nearly three-quarters of respondents described emotional support from healthcare providers as very important (73.3%, n = 11), while another 20% (n = 3) considered it somewhat important. One participant selected a neutral response (6.7%, n = 1).

Patient perspectives regarding interpreter emotional support were similarly positive. As shown in Figure 29, most participants believed interpreters should provide the same level of emotional support as other healthcare providers (66.7%, n = 10). Additional participants believed interpreters should provide emotional support, although to a lesser degree than other healthcare professionals (20%, n = 3). Two participants believed interpreters should provide emotional support using a different approach (13.3%, n = 2). No participants indicated interpreters should avoid providing emotional support altogether.

Figure 29

Patient Perspectives on Whether Interpreters Should Provide the Same Emotional Support as Healthcare Providers



Before meeting with interpreters, participants most commonly expected interpreters to only interpret conversations (86.7%, n = 13). However, additional expectations were also reported, including interpreters speaking up for patient needs (53.3%, n = 8), helping patients feel less alone (26.7%, n = 4), assisting with cultural understanding (13.3%, n = 2), and providing comfort during difficult moments (13.3%, n = 2). One participant indicated uncertainty regarding what to expect from interpreter services prior to healthcare encounters (6.7%, n = 1).

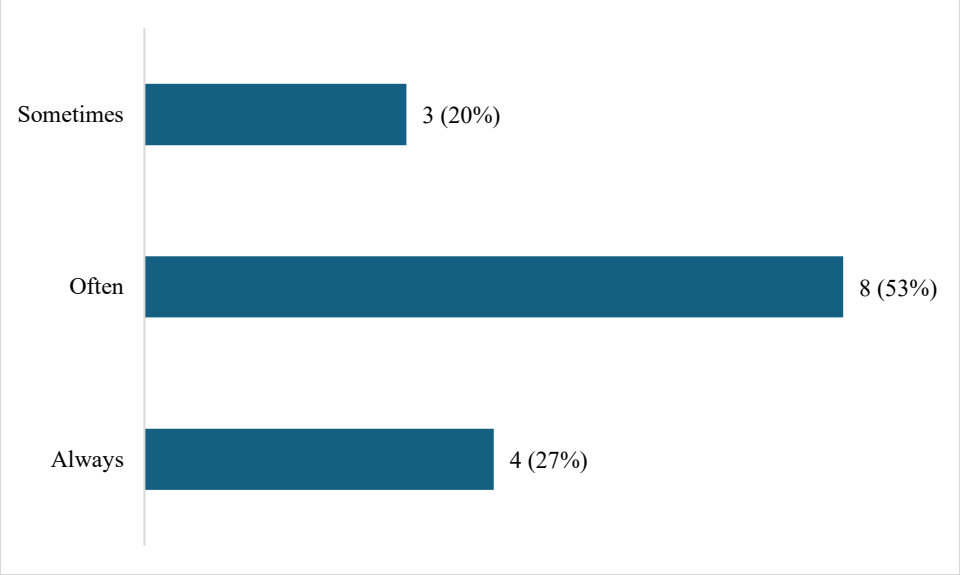
Interpreter Integration Within the Healthcare Team, Cultural Understanding, and Patient Satisfaction

Participants frequently described interpreters as central figures within their healthcare experiences, particularly in relation to language access and cultural understanding. As shown in Figure 30, most participants reported that interpreters were often the only member of the healthcare team who spoke their preferred language. More than half indicated this occurred often (53.3%, n = 8), while 26.7% (n = 4) reported interpreters were always the only person who spoke

their language. An additional 20% (n = 3) reported this occurred sometimes. No participants selected rarely or never.

Figure 30

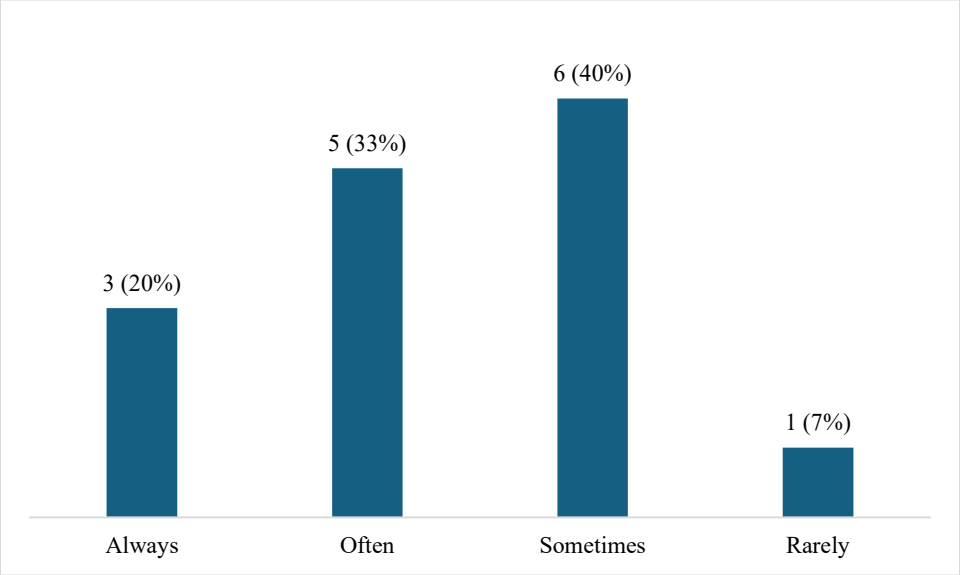
Frequency of Interpreters Being the Only Member of the Healthcare Team Who Spoke the Patient's Preferred Language



Participants similarly reported that interpreters were frequently the only individuals within healthcare encounters who understood their culture. As illustrated in Figure 31, 33.3% (n = 5) indicated interpreters often served as the only person on the healthcare team who understood their cultural background, while 20% (n = 3) reported this always occurred. Another 40% (n = 6) selected sometimes, and one participant selected rarely (6.7%, n = 1). No participants indicated interpreters never fulfilled this role.

Figure 31

Frequency of Interpreters Being the Only Member of the Healthcare Team Who Understood the Patient's Culture



Cultural understanding was also associated with increased patient comfort. Most participants reported feeling much more comfortable when interpreters understood their culture (66.7%, n = 10), while 26.7% (n = 4) reported feeling somewhat more comfortable. One participant indicated their interpreter did not understand their culture (6.7%, n = 1).

Patients overwhelmingly viewed interpreters as members of the healthcare team. Eighty percent of participants (n = 12) stated interpreters were definitely part of their healthcare team, while another 13.3% (n = 2) selected yes, somewhat. Only one participant reported not really considering interpreters part of the healthcare team (6.7%, n = 1).

When asked whether interpreters met their expectations, participant responses varied. One-third of participants reported interpreters did exactly what they expected (33.3%, n = 5), while another 33.3% (n = 5) stated interpreters were more beneficial than expected. Four participants reported interpreters were less beneficial than expected (26.7%, n = 4). No

participants selected different from what I expected, and one participant indicated uncertainty regarding expectations prior to receiving interpreter services (6.7%, n = 1).

Overall satisfaction with interpreter services was high among participants. Nearly half reported being very satisfied with interpreter services (46.7%, n = 7), while 40% (n = 6) described themselves as satisfied. One participant selected a neutral response (6.7%, n = 1), and one participant reported dissatisfaction with interpreter services (6.7%, n = 1). No participants described themselves as very unsatisfied.

Participants also expressed strong willingness to recommend interpreter services to others who speak their language. Most respondents indicated they would definitely recommend interpreter services (73.3%, n = 11), while another 20% (n = 3) selected yes, probably. One participant selected probably not (6.7%, n = 1), and no participants selected not sure or definitely not.

Qualitative Findings

In addition to the quantitative survey responses, participants were invited to provide open-ended comments regarding their experiences with medical interpreters and suggestions for improving interpreter services. A total of 15 Spanish-speaking patients contributed qualitative responses. To protect participant confidentiality, responses are identified using participant numbers (e.g., Patient 1, Patient 2). All comments were originally submitted in Spanish and translated into English by the researcher. Every effort was made to preserve the original meaning, tone, and intent of participants' responses while producing translations that were clear and understandable for an English-speaking audience.

Thematic analysis of the responses revealed three primary themes: (a) accurate interpretation as the foundation of trust, (b) emotional support and patient comfort, and (c) patient perspectives on high-quality interpreter services. The following sections present representative comments from participants within each theme.

Accurate Interpretation as the Foundation of Trust

For many patients, the value of interpreter services began with a simple expectation: accurate communication. Responses consistently emphasized the importance of interpreters conveying information faithfully between patients and healthcare providers. Regardless of their views on emotional support, cultural understanding, or other aspects of the interpreter role, patients repeatedly returned to the need for accurate and complete interpretation as the foundation of a positive healthcare experience.

Several respondents described interpretation as the interpreter's primary responsibility. One patient stated plainly, "Interpreters only convey what is said and nothing more" (Patient 3), while another shared, "I've only worked with interpreters who solely translated" (Patient 8). Similarly, Patient 4 explained, "When I need an interpreter, what I expect is for them to translate what is actually being said."

In addition to facilitating communication, accurate interpretation was closely connected to patients' ability to understand their medical care and participate confidently in healthcare encounters. As one parent explained, "Having interpreters who can translate perfectly is a huge help to us as parents, since we don't feel the pressure of not understanding what the medical staff is saying" (Patient 4). Another respondent described interpretation simply as "essential" (Patient 9), while Patient 15 reflected that interpreter services "have been a huge help," particularly

during an ongoing health condition that required frequent interactions with the healthcare system.

Not all experiences were positive. Several patients voiced concerns about interpreter accuracy and preparation, particularly when they possessed some English proficiency and could compare what was said in both languages. One respondent noted, “Sometimes they don't interpret what I say correctly, and I notice because I understand some English” (Patient 8). A similar concern was expressed by Patient 4, who commented that while many interpreters do an excellent job, there are occasions when “from the little English I know, I can tell [they] are translating things that have nothing to do with what the doctor is saying.” Others stressed the importance of preserving meaning during interpretation. As Patient 8 explained, interpreters should “interpret what we say without changing the meaning of the message.”

Emotional Support and Patient Comfort

Many patients described healthcare encounters as experiences that extended beyond the exchange of information through an interpreter. Responses frequently reflected the emotional challenges associated with illness, uncertainty, and navigating the healthcare system in a language other than one's preferred language. Within that context, several patients described interpreters as a source of comfort during difficult moments.

Expressions of comfort and reassurance appeared throughout the responses. Patient 2 shared, “When I have an interpreter, I feel more comfortable,” while Patient 12 explained that interpreters “give you peace of mind and make you feel more comfortable expressing yourself.” For Patient 15, interpreter services had been “a huge help,” particularly while managing ongoing health concerns.

Stress and vulnerability were also recurring themes. As Patient 13 explained, “Emotional support is very important because the patient is under a lot of stress.” A similar sentiment was expressed by Patient 15, who noted that “going through a medical treatment is frustrating enough as it is, so having emotional support would make the whole experience much easier to handle.” Another patient captured the complexity of navigating healthcare by observing that “hospitals are tricky and you need all the support you can get” (Patient 1).

Several responses suggested that feeling understood was just as important as understanding medical information. Reflecting on challenging medical situations, Patient 8 remarked, “These are difficult times, and it’s always important to feel that people understand you. Besides, kindness always helps prevent a bad diagnosis or at least makes it a little easier to bear.”

Among the responses, one account stood out for its highly personal nature. One patient described the impact a particular interpreter had on their healthcare experience, explaining, “I wasn't in good emotional shape before Elena started translating for me, I was a different person. All I can say is that she's really good at translating” (Patient 11).

In addition to emotional reassurance, some patients described receiving support that extended beyond language interpretation. Patient 13 noted that interpreters had “gave me some helpful suggestions,” while Patient 15 explained that their interpreter had been “very helpful, not only with translation but also with guidance throughout the entire process.”

Patient Perspectives on High-Quality Interpreter Services

Patients frequently commented on the qualities they valued most in medical interpreters, offering insights into what they believed contributed to effective interpreter services. Their

responses highlighted the importance of language proficiency, professional preparation, opportunities for meaningful communication, interpersonal skills, and, for some respondents, the modality through which services were delivered.

Strong language skills and interpreter preparation were recurring expectations throughout the responses. Patient 14 emphasized that interpreters should have “a very good command of the language we need to communicate in,” noting that their own interpreter's fluency had been “a huge help.” Positive assessments of interpreter competence also appeared elsewhere in the data. Patient 12 described their interpreter's “ability to understand” as “excellent,” while another respondent stated simply that “their help is very valuable” (Patient 12).

Not all patients felt interpreter preparation was consistent. Patient 4 commented that “sometimes, the interpreters aren't prepared well enough.” Another respondent suggested that interpreters would benefit from developing greater familiarity with specific medical specialties and departments, explaining that a better understanding of areas such as cardiology and gastroenterology could improve the patient experience (Patient 1).

Patients also expressed a desire for opportunities to communicate fully during healthcare encounters. One respondent voiced frustration that some interpreters encouraged only brief responses, explaining that “most of the time they only want short answers, and that limits our ability to ask questions and voice our concerns” (Patient 3). The same patient later suggested that interpreters should allow both healthcare providers and patients “to speak fully.”

Interpersonal interactions were another aspect of interpreter services that patients discussed. According to Patient 7, some interpreters were “so serious that I didn't feel comfortable or confident asking questions.” Similar observations appeared elsewhere in the data.

Patient 8 remarked that “some are very kind, while others seem rushed or act like robots,” suggesting that demeanor and approachability influenced how comfortable patients felt during healthcare encounters.

Preferences regarding service modality also emerged in several responses. Reflecting on their experiences, Patient 7 shared, “They’re very helpful, but personally, I'd prefer to always have an in-person interpreter. I feel more confident that way.” Patient 6 similarly distinguished between modalities, explaining that interpreters working remotely should focus primarily on interpretation, whereas in-person interpreters may be able to provide additional support when circumstances allow.

Concerns about remote interpreting services were raised by several patients. Patient 2 referenced “the restrictions they impose and their limited knowledge when sessions are conducted through video calls.” A similar concern was expressed by Patient 3, who suggested that some video interpreters would benefit from additional medical interpreter training because “sometimes they say things that have nothing to do with what is actually being discussed.”

Although respondents identified several areas they believed could be improved, not all patients reported concerns. Patient 10 stated, “No, I haven't had any issues of any kind,” reflecting the positive experiences many patients described throughout the survey.

Chapter 5: Discussion

In this study, I explored the hidden roles healthcare interpreters perform beyond linguistic mediation and examined how these contributions are perceived by healthcare interpreters, healthcare providers, and Spanish-speaking LEP patients. Chapter 4 presented the quantitative and qualitative findings from each participant group. The purpose of this chapter is to interpret those findings in relation to the research questions posed in Chapter 1, existing literature, and the theoretical framework guiding this study.

Specifically, this chapter addresses four research questions: (1) What contributions do healthcare interpreters make to patient care, provider workflow, and healthcare delivery beyond facilitating communication? (2) How do interpreters, healthcare providers, and patients perceive these contributions? (3) To what extent do healthcare interpreters engage in activities beyond linguistic mediation, such as cultural mediation, emotional support, care coordination, and patient advocacy? (4) How do interpreters navigate the ethical tensions that arise when patient needs appear to conflict with traditional expectations of professional neutrality? (5) Are important aspects of interpreter work overlooked by existing measures of productivity, performance, and value within healthcare organizations?

Drawing upon the perspectives of healthcare interpreters, healthcare providers, and Spanish-speaking LEP patients, this chapter examines areas of agreement and divergence across stakeholder groups while considering how the findings support, extend, or challenge existing scholarship. Particular attention is given to the relationship between professional standards, everyday practice, and the realities of healthcare encounters involving patients who face linguistic and cultural barriers. The chapter concludes with implications for healthcare organizations, healthcare interpreters, interpreter education, and professional organizations and

certifying bodies, followed by a discussion of study limitations, recommendations for future research, and concluding reflections on the broader significance of the findings.

Research Question 1: Beyond facilitating communication, what contributions do healthcare interpreters make to patient care, provider workflow, and healthcare delivery?

The findings of this study suggest that healthcare interpreters contribute to patient care, provider workflow, and healthcare delivery in ways that extend far beyond linguistic mediation alone. Across healthcare interpreters, healthcare providers, and Spanish-speaking limited English proficient (LEP) patients, participants consistently described interpreters as individuals who help patients participate more fully in healthcare encounters, navigate complex healthcare systems, and overcome communication barriers that might otherwise negatively affect care. These findings support previous research demonstrating the positive impact of professional interpreters on patient outcomes (Flores et al., 2012; Joseph et al., 2018; Kwan et al., 2023), while also highlighting contributions that are often less visible within traditional descriptions of interpreter practice.

One of the clearest findings across all three participant groups involved the role interpreters play in promoting patient comfort, trust, and participation during healthcare encounters. Among Spanish-speaking LEP patients, 73.3% reported feeling much more comfortable when working with an interpreter who spoke their preferred language, while the remaining 26.7% reported feeling somewhat more comfortable. No participants reported feeling less comfortable when an interpreter was present. Patients frequently emphasized the importance of both accuracy and human connection. One participant explained that interpreters who appeared rushed or detached negatively affected their comfort level, while others highlighted the

value of interpreters who were approachable, attentive, and caring. As one parent explained, "Having interpreters who can translate perfectly is a huge help to us as parents, since we don't feel the pressure of not understanding what the medical staff is saying" (Patient 4). Another respondent described interpreter services simply as "essential" (Patient 9). These findings suggest that interpreter contributions extend beyond facilitating communication to creating an environment in which patients feel more comfortable asking questions, expressing concerns, and participating in their care.

Healthcare providers similarly recognized the value interpreters bring beyond language transfer alone. Nearly all providers reported observing interpreters step in to assist during situations involving communication difficulties or patient needs beyond direct interpretation. More than one-third (36.8%) reported observing these activities frequently, while an additional 57.9% reported observing them occasionally. Furthermore, 78.9% of providers described these activities as very beneficial to patient care, while 15.8% viewed them as somewhat beneficial. These findings suggest that providers frequently witness interpreters contributing to patient care in ways that extend beyond message transfer and recognize these contributions as valuable components of healthcare delivery.

Interpreters themselves reported contributing to patient outcomes through a combination of language interpretation and activities beyond interpreting. While 54.7% reported contributing primarily through language interpretation, an additional 41.5% reported contributing through both interpretation and tasks beyond interpreting. Qualitative responses further illustrated how interpreters conceptualized their broader contributions to patient care. Participants described helping patients navigate healthcare systems, identify resources, understand healthcare processes, and overcome barriers that remained unresolved after provider interactions had concluded.

Several interpreters noted that patients often continued speaking with them after providers left because they felt more comfortable communicating with someone who shared their language and cultural background. Others described assisting with transportation applications, appointment reminders, referrals, paperwork, and patient portals. These findings suggest that interpreters frequently function as informal navigators within healthcare systems, helping patients access services and information that might otherwise remain difficult to understand or obtain.

The findings also indicate that interpreters contribute to provider workflow and the overall delivery of healthcare. Providers identified patient confusion or distress (89%) and provider communication difficulties (84%) as the most common situations prompting interpreter involvement beyond direct interpretation. These findings suggest that interpreters often serve as linguistic and cultural resources when communication challenges arise. Qualitative responses from interpreters further highlighted the importance of collaboration with healthcare providers, preparation before encounters, continuity of care, and familiarity with patient circumstances. Participants frequently described effective healthcare interpreting as dependent upon relationships, preparation, and communication rather than language proficiency alone. These findings align with Plys et al. (2024), who found that interpreters embedded within healthcare systems often function as collaborative partners who support continuity of care and facilitate communication across complex healthcare environments.

Another important contribution identified in this study involved the role interpreters play in recognizing and responding to communication barriers before they negatively affect patient care. Most interpreters reported noticing either significant differences (66%) or some differences (30%) in their ability to support LEP patients depending on the interpreting modality used.

Participants consistently emphasized factors such as medical terminology knowledge (n = 145), interpreter skill and experience (n = 132), language proficiency (n = 115), understanding of the U.S. healthcare system (n = 110), cultural knowledge (n = 109), and provider training on how to work with interpreters (n = 108) as essential components of quality care. Taken together, these findings suggest that interpreters view effective healthcare communication as a multidimensional process involving linguistic, cultural, relational, and systemic factors. Rather than serving solely as transmitters of information, interpreters frequently described identifying misunderstandings, recognizing gaps in patient understanding, and helping address barriers that could affect healthcare outcomes.

Viewed through the lens of Muted Group Theory, these findings suggest that healthcare interpreters play an important role in helping LEP patients participate more fully within healthcare systems that were not designed around their language or cultural experiences. According to Muted Group Theory, members of non-dominant groups often struggle to have their perspectives fully recognized within institutions shaped by the language and assumptions of dominant groups. Healthcare interpreters occupy a unique position within this dynamic.

By facilitating communication, providing cultural context, supporting patient understanding, and helping patients navigate healthcare systems, interpreters help reduce barriers that might otherwise limit patient participation. The high levels of comfort reported by patients, the recognition of interpreter contributions by providers, and interpreters' own descriptions of their work collectively suggest that interpreters do more than facilitate communication. They help ensure that patient voices are heard, understood, and incorporated into healthcare decision-making processes.

In general, the findings indicate that healthcare interpreters contribute to patient care, provider workflow, and healthcare delivery by helping LEP patients participate more fully in healthcare encounters. Through relationship-building, system navigation, cultural knowledge, communication expertise, and ongoing support, interpreters help bridge gaps that extend beyond language alone. Consistent with Muted Group Theory, these contributions may be understood as efforts to reduce structural barriers to participation and promote more equitable healthcare experiences for patients whose voices might otherwise remain unheard.

Research Question 2: How do interpreters, healthcare providers, and patients perceive interpreters' contributions beyond linguistic mediation?

While Research While Research Question 1 explored the types of contributions interpreters reported providing beyond linguistic mediation, Research Question 2 examined how those contributions were perceived by interpreters, healthcare providers, and patients. Across all three stakeholder groups, the findings revealed broad recognition that interpreters contribute to healthcare encounters in ways that extend beyond the transfer of language alone. Participants frequently described interpreters as supporting communication, facilitating cultural understanding, providing emotional support, assisting with healthcare navigation, and contributing to patient-centered care. Although perceptions differed regarding where professional boundaries should be drawn, there was substantial agreement that interpreters provide value beyond the traditional conduit model.

One of the most striking findings was the degree of consensus across stakeholder groups. Existing literature often presents expanded interpreter roles as ethically complex or potentially controversial. However, participants in this study demonstrated broad agreement that interpreters

contribute to healthcare encounters in ways that extend beyond language transfer alone. Interpreters described performing these activities, providers reported observing and valuing them, and patients frequently expressed appreciation for them. Disagreement centered less on whether these contributions occurred and more on where professional boundaries should be drawn and how such activities should be integrated into professional practice.

Healthcare providers expressed overwhelmingly positive perceptions regarding interpreter contributions beyond linguistic mediation. When asked how these activities affected patient care, 78.9% described them as very beneficial and an additional 15.8% described them as somewhat beneficial. No providers characterized these contributions as problematic. Similarly, providers identified numerous benefits associated with interpreter involvement beyond language transfer. Better communication (94.7%) and increased patient trust (94.7%) were the most frequently identified benefits, followed by reduced patient anxiety (89.5%), improved cultural understanding (89.5%), improved patient comfort (84.2%), and better health outcomes (63.2%). These findings suggest that healthcare providers frequently perceive interpreter contributions as influencing not only communication accuracy but also the overall quality of patient care and the patient experience.

Patient perceptions were similarly positive. Nearly three-quarters of participants (73.3%) reported feeling much more comfortable when communicating through an interpreter who spoke their preferred language, while the remaining 26.7% reported feeling somewhat more comfortable. No participants reported feeling less comfortable when an interpreter was present. Patients also reported receiving assistance beyond language interpretation in areas such as scheduling appointments, understanding medical procedures, navigating healthcare systems, and advocating for patient needs. More importantly, these forms of assistance were overwhelmingly

viewed as useful. Qualitative responses frequently associated interpreters with feelings of comfort, understanding, reassurance, and cultural connection. Many participants described interpreters as helping them feel less alone during stressful healthcare encounters and serving as trusted sources of support during difficult conversations.

Patient responses also revealed strong support for interpreter emotional support. Two-thirds of participants (66.7%) believed interpreters should provide the same level of emotional support as other healthcare providers, while an additional 20% believed interpreters should provide emotional support at a somewhat different level. No participants indicated that interpreters should avoid providing emotional support altogether. These findings suggest that many patients view emotional support not as a departure from the interpreter role, but as an expected component of quality care.

Interpreter perceptions largely mirrored these findings while simultaneously revealing the ethical complexity underlying such contributions. Most interpreters viewed their role as extending beyond language transfer alone. While 54.7% reported contributing primarily through language interpretation, 41.5% indicated that they contributed through both interpretation and activities beyond interpreting. Participants frequently described rapport-building, emotional presence, cultural explanation, patient advocacy, communication monitoring, and patient safety interventions as meaningful aspects of their work. At the same time, interpreters remained highly aware of professional boundaries and ethical responsibilities. Although most respondents reported high levels of confidence in maintaining professional ethics while providing emotional support, many also described navigating recurring situations that involved ethical uncertainty, competing responsibilities, and difficult judgment calls.

These findings align with previous scholarship suggesting that healthcare interpreting is best understood as a practice profession rather than a purely technical linguistic activity (Dean, 2021; Sielen, 2023). Dean argued that interpreters engage in ongoing contextual decision-making that requires professional judgment, while Sielen found that interpreters frequently employ sophisticated ethical reasoning even when they struggle to articulate the rationale behind their decisions. The perceptions expressed by participants in the present study support these conclusions. Rather than viewing interpreters as passive transmitters of information, stakeholders frequently described them as active contributors to communication quality, patient understanding, and overall healthcare experiences.

The findings also support emerging literature that challenges traditional conduit-based models of interpreting. Rusho (2023) argued that strict neutrality often fails to reflect the realities of practice, particularly in settings where interpreters serve culturally and linguistically marginalized populations. Similarly, Yuan (2022) described interpreters as individuals who continuously negotiate professional expectations alongside personal values and social responsibilities. Participants in the present study frequently described interpreters as occupying a unique position within healthcare encounters, one that involves balancing professional responsibilities with responsiveness to patient needs. Patients, providers, and interpreters alike often perceived activities such as cultural explanation, communication facilitation, emotional support, and advocacy as beneficial components of quality care rather than inappropriate role expansion.

Research Question 3: To what extent do healthcare interpreters engage in activities beyond linguistic mediation, such as cultural mediation, emotional support, care coordination, and patient advocacy?

Evidence from interpreters, healthcare providers, and patients collectively indicates that activities beyond linguistic mediation are a regular part of healthcare interpreting practice. Across survey responses and qualitative comments, participants described interpreters engaging in a broad range of activities that extended beyond language transfer, including emotional support, cultural mediation, patient advocacy, healthcare navigation, and care coordination. Although the frequency and nature of these activities varied across settings and circumstances, the data suggest that they are not isolated occurrences. Rather, they appear to be woven into the day-to-day realities of healthcare encounters involving LEP patients.

One of the clearest indicators of this broader involvement was the finding that 79.2% of interpreters reported assisting patients directly with tasks beyond interpreting when providers were unavailable. Advocacy for patient needs emerged as one of the most commonly reported activities, followed by cultural mediation, emotional support, and assistance with logistical challenges. While some activities occurred more frequently than others, the overall pattern suggests that many interpreters regularly encounter situations in which language interpretation alone does not fully address patient needs.

Emotional support occupied a particularly prominent place within the findings. Half of interpreter respondents reported rarely providing emotional support, while an additional 25.8% indicated doing so occasionally. Only 18.2% reported never engaging in this type of support. Although emotional support was not described as a routine component of every encounter, it was

clearly not an unusual occurrence either. Instead, respondents portrayed it as something that arose during moments of heightened vulnerability, uncertainty, or distress.

The circumstances surrounding emotional support were equally revealing. Situations involving culturally appropriate care were selected most frequently (57%), followed by delivering difficult news (50%), frightening procedures (44%), and encounters involving patients who were alone and distressed (43%). These findings suggest that emotional support often emerged when communication challenges intersected with fear, grief, isolation, or cultural differences. Rather than occurring randomly, support tended to arise in situations where patients were experiencing significant emotional or psychological strain.

Qualitative responses provided additional context regarding how interpreters viewed these interactions. Many described communication as involving much more than the transmission of words. Participants frequently referenced emotional presence, rapport-building, and compassionate communication as important components of effective practice. One interpreter observed that "the tone of voice and the words chosen by the interpreter in difficult situations is what the patient is going to remember" (Interpreter 2), while another emphasized the importance of helping patients feel understood and comfortable expressing concerns (Interpreter 151). Throughout the responses, interpreters repeatedly challenged the notion that professionalism requires emotional detachment. Statements such as "we are not robots" (Interpreters 63, 85, 153) and "interpreters are not machines" (Interpreter 149) reflected a shared belief that healthcare interpreting is fundamentally relational as well as linguistic.

At the same time, participants did not advocate for unlimited emotional involvement. Discussions of compassion were frequently accompanied by acknowledgements of professional boundaries. Several respondents emphasized the importance of maintaining objectivity while still

demonstrating humanity. Others described constantly balancing empathy, ethical obligations, and patient needs. These responses suggest that emotional support is not simply accepted or rejected within healthcare interpreting practice. Instead, it is often negotiated through ongoing professional judgment.

A second area of involvement concerned healthcare navigation and care coordination. Interpreters described helping patients schedule appointments, activate patient portals, locate services, understand follow-up instructions, obtain transportation, and access community resources. Many of these activities occurred after the interpreted encounter had ended, when patients continued to have questions or encountered barriers that interfered with access to care. Several respondents described becoming informal guides within healthcare systems that patients found confusing, unfamiliar, or difficult to navigate independently.

Equally notable was the extent to which these activities appeared to fill gaps within healthcare systems. Participants frequently recounted situations in which no other staff member was available to assist. Examples included helping patients complete paperwork, arranging transportation, connecting families with community resources, and ensuring that questions reached the appropriate healthcare professional. Rather than portraying these actions as deliberate attempts to expand the interpreter role, respondents generally framed them as practical responses to unmet needs encountered during patient care.

Long-term relationships with patients often appeared to deepen this involvement. Interpreters working in clinics, rehabilitation settings, oncology, and inpatient environments described repeated interactions with the same individuals and families over time. These ongoing relationships allowed interpreters to observe recurring challenges related to access, continuity of

care, patient understanding, and healthcare navigation. In many cases, familiarity with patients' circumstances increased awareness of barriers that might otherwise have remained unnoticed.

Beyond emotional support and navigation, advocacy emerged as another significant dimension of interpreter involvement. Participants described speaking up when they observed communication breakdowns, misunderstandings, safety concerns, literacy barriers, or situations that threatened informed decision-making. Many of these examples involved circumstances in which interpreters believed patients were at risk of making decisions without fully understanding available information. Others involved concerns related to discrimination, exclusion from decision-making processes, or failures to recognize important cultural or contextual factors.

What is particularly noteworthy about these examples is that respondents rarely framed them as acts of role expansion. Instead, interpreters often described advocacy as arising from their unique position within healthcare encounters. Because they were simultaneously listening, observing, and monitoring communication, they frequently became aware of misunderstandings, safety concerns, or unmet patient needs that were not immediately visible to others. Their descriptions suggest that advocacy was not viewed as a departure from the interpreter role, but rather as a difficult-to-define aspect of practice that emerged when communication breakdowns or potential harm became apparent. In this sense, advocacy occupied a space between strict message transfer and assuming responsibilities traditionally associated with other healthcare professionals.

Findings from healthcare providers and patients reinforced this broader picture of interpreter involvement. Providers reported regularly observing interpreters assist with appointment scheduling, procedural explanations, cultural mediation, emotional support, and patient advocacy. Patients similarly described receiving help with navigating healthcare systems,

understanding medical information, speaking up for their needs, and accessing resources. Importantly, neither group portrayed these activities as unusual events. Instead, they appeared to be recognized features of healthcare encounters involving interpreters. This convergence across stakeholder groups strengthens the conclusion that activities beyond linguistic mediation are widely embedded within contemporary healthcare interpreting practice.

From an MGT perspective, these findings suggest that many activities beyond linguistic mediation arise because language access alone is often insufficient to ensure meaningful participation in healthcare. Interpreters repeatedly described situations in which patients struggled to navigate healthcare systems, understand complex information, communicate concerns, or have their perspectives fully acknowledged. Activities such as advocacy, cultural mediation, emotional support, and care coordination can therefore be understood as responses to barriers that continue to limit participation for individuals whose voices are marginalized by linguistic and cultural differences. In this sense, interpreters are not only facilitating communication but also helping patients engage more fully with healthcare systems and decision-making processes.

Overall, the findings indicate that activities beyond linguistic mediation have become embedded within the realities of healthcare interpreting practice. Whether through emotional support, cultural mediation, patient advocacy, healthcare navigation, or communication management, interpreters frequently described responding to challenges that extended beyond language alone. Although opinions differed regarding the appropriate limits of these activities, the data demonstrate that they occur often enough to be recognized by interpreters, providers, and patients alike as recurring aspects of healthcare encounters rather than rare exceptions.

Research Question 4: How do interpreters navigate the ethical tensions that arise when patient needs appear to conflict with traditional expectations of professional neutrality?

Ethical tension emerged as a common feature of healthcare interpreting practice. The vast majority of interpreters (83.6%) reported encountering situations in which they believed they could support a patient but were uncertain whether doing so aligned with professional guidelines. Although these situations were not described as everyday occurrences, most respondents reported encountering them at least occasionally throughout their careers. Only 16.4% indicated they had never experienced this type of uncertainty. Taken together, these findings suggest that healthcare interpreters regularly encounter circumstances in which professional expectations and perceived patient needs do not align neatly.

The degree of conflict associated with these situations varied considerably. While some respondents reported only slight uncertainty, many described more substantial ethical tension. More than half of participants reported feeling moderately, very, or extremely conflicted when navigating situations involving potential support beyond traditional interpreting boundaries. These findings suggest that ethical decision-making is not a peripheral aspect of healthcare interpreting practice. Rather, it appears to be a recurring professional challenge requiring ongoing judgment and reflection.

Not all situations generated the same level of concern. The greatest sources of ethical conflict involved patient understanding, patient safety, and vulnerability rather than emotional support alone. The most frequently identified scenario involved patients agreeing to something interpreters suspected they did not fully understand (64%). Situations involving patients being discharged without adequate understanding or resources (58%) and patients receiving difficult

news without a support person present (57%) also ranked among the most challenging. In contrast, requests for physical comfort or emotional support generated comparatively lower levels of conflict. This pattern suggests that interpreters were particularly troubled by situations in which communication barriers appeared to threaten informed consent, patient comprehension, or safe participation in healthcare decision-making.

The factors that influenced interpreters' decisions further reinforce this interpretation. Potential consequences for the patient emerged as the most frequently selected consideration (74%), followed by the patient's level of distress (58%). Although concerns about professional boundaries remained important, respondents appeared more likely to prioritize the potential impact on patient wellbeing than strict adherence to role definitions alone. Availability of other staff members and relationships with healthcare providers also influenced decision-making, suggesting that interpreters frequently considered the broader clinical context when determining how to respond.

Qualitative responses revealed that interpreters rarely approached these situations through rigid rule application. Instead, participants frequently described ethical decision-making as a process of weighing competing obligations and evaluating the unique circumstances of each encounter. Phrases such as “depends on the situation,” “case by case,” and “gray area” appeared repeatedly throughout the data. Rather than describing a single decision-making framework, respondents referenced professional judgment, intuition, experience, and what some described as a “moral compass” when determining how to proceed. One interpreter explained, “If I strongly believe it will influence the care, outcome or cause unnecessary distress to an already severely ill person, I resort to judgment, lesser of two evils” (Interpreter 5). Another noted, “It depends,

sometimes I let my instinct win other times I stay away from crossing my boundaries" (Interpreter 19).

A recurring theme throughout the responses involved the perceived tension between professional neutrality and beneficence. Many interpreters expressed strong commitment to ethical standards while simultaneously questioning whether traditional interpretations of neutrality always served patients' best interests. One participant asked, "I have to abide by my code of ethics and standards of practice, but where do my protocols place my human side?" (Interpreter 31). Another described ethical decision-making as "a balance of our COE and human compassion" (Interpreter 146). Similar perspectives appeared throughout the dataset, reflecting a belief that professionalism and humanity are not necessarily opposing forces. As Interpreter 67 explained, "Our ethical and professional framework and our ability to be compassionate humans are not mutually exclusive."

At the same time, participants did not speak with one voice regarding the appropriate limits of interpreter involvement. Some respondents strongly supported traditional conduit-based approaches and emphasized maintaining strict role boundaries. Others argued that emotional support and compassionate engagement are unavoidable realities of healthcare encounters. Concerns about liability, role confusion, and subjectivity also appeared throughout the responses. For these participants, expanding interpreter involvement too far risked undermining impartiality and creating uncertainty regarding professional responsibilities. These contrasting perspectives suggest that disagreement often centered not on whether patient needs matter, but on how interpreters should respond when those needs appear to conflict with established role expectations.

Provider and patient perspectives added further context to these tensions. Although providers acknowledged concerns related to professional boundaries and role confusion, none characterized interpreter emotional support as unprofessional or inappropriate. Instead, most viewed emotional support as either beneficial or acceptable under certain circumstances. Similarly, patients overwhelmingly expressed positive attitudes toward interpreter involvement during emotionally difficult situations and frequently associated quality interpreting with kindness, reassurance, and feeling understood. These findings suggest that interpreters are often navigating ethical tensions within environments where patients and healthcare providers may expect a degree of human engagement that extends beyond literal message transfer.

Relating the findings back to MGT, many of these ethical tensions appear to arise when strict adherence to traditional role boundaries seems to conflict with a patient's ability to understand information, participate in decision-making, or have their concerns recognized within healthcare encounters. Interpreters frequently described situations in which remaining completely neutral felt difficult when communication barriers, cultural misunderstandings, or gaps in support threatened meaningful participation. In these circumstances, ethical decision-making often involved balancing professional impartiality against the potential consequences of inaction for patients facing linguistic and cultural barriers.

The findings suggest that healthcare interpreters navigate ethical tensions through contextual judgment rather than rigid adherence to a single professional philosophy. Respondents demonstrated strong awareness of ethical standards and role boundaries, yet many also described evaluating patient vulnerability, potential harm, emotional distress, informed consent, and available support before deciding how to respond. Rather than viewing neutrality and patient advocacy as mutually exclusive, many participants approached ethical decision-making as an

ongoing process of balancing competing responsibilities within the realities of patient care. These findings support previous scholarship suggesting that healthcare interpreting is fundamentally a practice profession requiring professional judgment, ethical reasoning, and situational awareness rather than simple rule application.

Research Question 5: Are important aspects of interpreter work overlooked by existing measures of productivity, performance, and value within healthcare organizations?

The findings of this study suggest that important aspects of healthcare interpreters' work may not be fully captured by the metrics commonly used to evaluate interpreter services within healthcare organizations. Throughout both the literature and participant responses, interpreter value was frequently discussed in terms of communication quality, patient understanding, trust, safety, and healthcare outcomes. In contrast, healthcare systems often evaluate interpreter services through measures that are easier to quantify, including encounter volume, interpreted minutes, utilization rates, staffing efficiency, response times, and compliance with language access requirements. While these measures provide important operational information, they do not adequately reflect many of the contributions described throughout this study.

Across interpreters, healthcare providers, and patients, participants consistently identified forms of value that extended beyond direct language transfer. Respondents described interpreters facilitating cultural understanding, reducing patient anxiety, strengthening trust between patients and providers, helping patients navigate healthcare systems, supporting informed decision-making, identifying communication breakdowns, and preventing misunderstandings that could negatively affect care. Interpreters additionally described serving as mentors, educators, cultural resources, communication consultants, and collaborative members of healthcare teams. Although

these contributions were repeatedly identified as beneficial, they are rarely reflected in traditional productivity reports or utilization statistics.

One of the most notable findings of this study was the consistency with which all three stakeholder groups identified these broader contributions. Providers overwhelmingly reported that interpreter involvement improved communication (95%), increased patient trust (95%), reduced patient anxiety (89%), enhanced cultural understanding (89%), and improved patient comfort (84%). Better health outcomes were identified by nearly two-thirds of providers (63%). Patients frequently described interpreters as helping them feel understood, reassured, supported, and less alone during healthcare encounters. Interpreters themselves reported regularly engaging in activities related to advocacy, cultural mediation, healthcare navigation, patient safety, and communication management. Collectively, these findings suggest that stakeholders frequently evaluate interpreter value through the impact interpreters have on healthcare experiences rather than through the volume of encounters completed.

A second pattern that emerged involved the largely invisible nature of much interpreter work. Throughout the study, participants described activities that occurred before, after, or outside formal interpreted encounters. Examples included helping patients navigate healthcare systems, connecting families to resources, identifying misunderstandings after appointments had ended, facilitating transportation arrangements, assisting with patient portals, and recognizing barriers to informed consent or continuity of care. These activities often occurred in response to immediate patient needs and were frequently described as efforts to address gaps within healthcare systems. Because many of these interactions take place outside documented interpretation sessions, their contribution to patient care may remain largely invisible within organizational measurement systems.

This disconnect reflects a broader challenge within healthcare. As Teisberg et al. (2020) and Hempel et al. (2021) observed, value-based healthcare emphasizes outcomes that matter to patients, including care quality, patient experience, care coordination, trust, and health outcomes. Yet healthcare organizations frequently continue to rely on metrics that prioritize efficiency, productivity, and utilization. Findings from the present study suggest interpreter services face a similar challenge. Many of the contributions participants viewed as most valuable were relational, preventative, and contextual in nature. Their significance often became apparent only when considering what might have happened in their absence. An interpreter who prevents a misunderstanding, facilitates informed consent, improves communication, or helps a patient successfully navigate healthcare services may create substantial value without generating any measurable increase in encounter volume or productivity.

Another noteworthy finding involved the role of professional judgment. Earlier research questions demonstrated that interpreters routinely encounter ethical tensions involving patient understanding, discharge planning, emotional vulnerability, and informed decision-making. Respondents frequently described relying on contextual judgment, professional experience, and ethical reasoning when determining how to respond. These forms of decision-making require expertise that extends beyond language proficiency alone. However, they are difficult to quantify and are rarely included in formal performance measures despite their importance to safe and effective healthcare communication.

Muted Group Theory provides an additional lens through which to understand why these contributions may remain undervalued. The theory suggests that dominant institutions often privilege certain forms of knowledge while overlooking others. Within healthcare systems, productivity measures are typically designed around organizational priorities such as efficiency,

throughput, and utilization. As a result, contributions related to communication quality, trust, cultural understanding, patient participation, and patient voice may be less visible despite their importance. Interpreters occupy a unique position between healthcare institutions and patients with limited English proficiency, often recognizing barriers, concerns, misunderstandings, and unmet needs that are not captured through conventional performance metrics. In many cases, successful interpreter interventions are reflected not in visible outcomes but in the absence of problems: misunderstandings avoided, barriers removed, safety concerns prevented, and patient voices successfully heard.

The findings also raise questions regarding how healthcare organizations define interpreter value. Traditional conduit-based models and productivity-focused evaluation systems emphasize language transfer as the interpreter's primary function. Yet participants across all three stakeholder groups consistently described interpreters as contributing to communication quality, healthcare navigation, cultural responsiveness, patient engagement, emotional wellbeing, and patient safety. This creates a potential mismatch between how interpreter services are evaluated and how interpreter contributions are experienced within healthcare encounters.

Ultimately, the findings suggest that existing measures of productivity and performance capture only part of the value healthcare interpreters provide. Encounter volume, utilization rates, and operational metrics remain important, but they do not fully account for the relational, cultural, ethical, and collaborative dimensions of interpreter work identified throughout this study. Across interpreters, providers, and patients, these less visible contributions emerged as recurring and highly valued aspects of care. The findings therefore suggest that healthcare organizations may be measuring interpreter productivity while overlooking important dimensions of interpreter value. Recognizing and accounting for these contributions may provide

a more complete understanding of the role interpreters play in supporting patient-centered care, health equity, communication quality, and equitable healthcare delivery.

Implications of the Study

The purpose of this study was not only to better understand the roles healthcare interpreters perform beyond linguistic mediation, but also to examine what those roles reveal about communication, patient care, and language access within modern healthcare systems. Across all three stakeholder groups, a consistent message emerged: healthcare interpreters are frequently called upon to contribute in ways that extend beyond the transfer of language alone. Whether assisting patients during emotionally difficult moments, helping providers navigate cultural differences, supporting communication during complex encounters, or helping patients understand how to access care, interpreters were often described as important contributors to the healthcare experience.

These findings carry implications that extend beyond the interpreting profession itself. They raise important questions about how healthcare organizations define value, how interpreters are prepared for practice, and how professional standards can evolve to reflect the realities of contemporary healthcare environments.

Implications for Healthcare Organizations

One of the clearest messages emerging from this study is that interpreter services cannot be fully understood through productivity metrics alone. Most healthcare organizations can easily measure encounter volume, interpreted minutes, staffing ratios, utilization rates, and response times. These indicators are useful for operational planning, but they tell only part of the story.

The experiences shared by interpreters, providers, and patients suggest that some of the most meaningful contributions interpreters make are also among the most difficult to quantify. Trust-building, cultural understanding, communication facilitation, emotional support, and the prevention of misunderstandings rarely appear on productivity reports, yet participants repeatedly identified these activities as valuable components of patient care. In many cases, the impact of these contributions may only become apparent when they are absent.

As healthcare systems increasingly embrace patient-centered care and health equity initiatives, there may be value in reconsidering how interpreter services are evaluated. Metrics focused exclusively on volume and efficiency risk overlooking contributions that directly affect patient experiences and communication quality. Incorporating measures related to patient satisfaction, provider collaboration, communication outcomes, and cultural responsiveness may provide a more complete picture of interpreter value within healthcare organizations.

The findings also point to the importance of meaningful interpreter integration within healthcare teams. Throughout the study, providers described turning to interpreters for cultural insight, communication guidance, and assistance navigating challenging interactions. Rather than functioning solely as language resources, many interpreters appeared to occupy collaborative roles that supported broader healthcare goals. Organizations that encourage interdisciplinary collaboration and recognize interpreters as communication specialists may be better equipped to address the needs of increasingly diverse patient populations.

Another implication involves the way language access programs are positioned within healthcare institutions. Compliance with federal language access requirements remains essential, but the findings suggest that interpreter services contribute to healthcare quality in ways that extend beyond regulatory obligations. Viewing interpreter programs primarily through a

compliance lens may inadvertently minimize their role in promoting patient trust, improving communication, supporting informed decision-making, and advancing health equity. A broader perspective may allow healthcare organizations to more fully recognize the expertise interpreters bring to patient care.

Implications for Healthcare Interpreters

The findings of this study suggest that healthcare interpreters operate within a level of professional complexity that is not always reflected in traditional descriptions of the role. Across quantitative and qualitative responses, participants described regularly encountering situations involving emotional distress, cultural misunderstandings, patient safety concerns, communication breakdowns, and competing ethical responsibilities. Rather than functioning solely as linguistic intermediaries, many interpreters reported balancing multiple demands simultaneously while attempting to support effective communication and maintain professional boundaries.

One implication of these findings is the importance of recognizing ethical uncertainty as a normal aspect of healthcare interpreting practice. Participants frequently described situations in which there was no obvious or universally accepted course of action. Decisions involving emotional support, patient advocacy, cultural mediation, or communication facilitation often required interpreters to weigh competing responsibilities and evaluate potential consequences. These findings suggest that ethical tension should not necessarily be viewed as evidence of professional failure or inadequate training. Instead, it may reflect the reality of working in complex healthcare environments where patient needs, provider expectations, institutional policies, and professional standards do not always align perfectly.

The findings also highlight the value of reflective practice. Because healthcare encounters vary considerably in their clinical, cultural, and interpersonal dynamics, interpreters often face situations that cannot be resolved through rigid application of rules alone. Participants frequently described drawing upon professional judgment, experience, and contextual awareness when making decisions. Developing habits of reflection before, during, and after challenging encounters may help interpreters better understand their decision-making processes and navigate future situations with greater confidence. This observation is consistent with Dean's (2021) description of healthcare interpreting as a practice profession that relies on ongoing reflection and contextual reasoning.

Another implication involves professional identity. Throughout the study, interpreters described contributions that extended beyond language transfer, including facilitating understanding, supporting communication, helping patients navigate healthcare systems, and serving as cultural resources for healthcare teams. While these activities should not be interpreted as justification for unlimited role expansion, they do suggest that healthcare interpreting involves a broader range of competencies than linguistic proficiency alone. Recognizing the full scope of these contributions may help interpreters better understand the value they bring to healthcare encounters and the impact their work can have on patient experiences.

The findings additionally draw attention to the emotional dimensions of healthcare interpreting. Participants frequently reported working in situations involving grief, fear, uncertainty, trauma, and serious illness. Many described providing support during emotionally charged encounters while simultaneously managing their own reactions and maintaining

professional composure. These experiences reinforce the importance of self-awareness, peer support, supervision, and professional development opportunities that address the emotional demands of healthcare interpreting. As previous research on vicarious trauma and interpreter wellbeing has demonstrated, sustained exposure to difficult clinical situations can affect interpreters both professionally and personally.

Finally, the findings suggest that healthcare interpreters may benefit from viewing professional growth as extending beyond language acquisition and terminology development. While linguistic competence remains essential, participants repeatedly described situations that required communication skills, cultural awareness, ethical reasoning, emotional intelligence, and collaboration with healthcare professionals. Continued growth in these areas may better prepare interpreters for the realities of contemporary healthcare practice and strengthen their ability to navigate the complex situations they encounter throughout their careers.

Viewed collectively, the findings illustrate a profession that extends far beyond the transfer of language alone. Healthcare interpreters routinely navigate linguistic, cultural, ethical, and interpersonal complexities while helping patients and providers communicate across barriers that might otherwise compromise understanding and care. Recognizing the full scope of these responsibilities may help interpreters better appreciate the value of their contributions while encouraging continued growth in the skills needed to navigate an increasingly complex healthcare environment.

Implications for Interpreter Education and Training

One of the clearest lessons emerging from this study is that healthcare interpreting cannot be reduced to language transfer alone. Although interpreter training has traditionally emphasized

language proficiency, terminology, modes of interpretation, and professional ethics, the realities described by participants reveal a profession that regularly requires far more. Interpreters in this study discussed navigating emotionally charged conversations, addressing cultural misunderstandings, responding to patient distress, supporting communication during moments of uncertainty, and making difficult decisions when competing obligations collided. Preparing interpreters for these realities requires educational approaches that extend beyond technical skill development.

Perhaps the most significant implication involves the way ethics is taught. Professional codes of ethics remain essential, but knowing a code is not the same as knowing how to apply it when a patient is crying, a provider is rushing through complex information, or a misunderstanding carries potential consequences for patient safety. Many interpreters in this study were not struggling because they lacked knowledge of ethical principles. They were struggling because multiple ethical responsibilities often existed simultaneously. Future educational efforts may benefit from placing greater emphasis on ethical reasoning, decision-making frameworks, and opportunities to work through realistic scenarios where there is no single correct answer.

The profession may also benefit from creating more space for uncertainty. Students are often introduced to professional roles through clearly defined examples and expectations. Real healthcare encounters are rarely that tidy. Experienced interpreters frequently described situations that required judgment, adaptability, and the ability to respond to circumstances as they unfolded. Case studies, facilitated discussion, mentorship, and reflective practice activities

may help bridge the gap between classroom learning and professional reality by allowing learners to explore the gray areas they are likely to encounter in practice.

Another area worthy of greater attention is the emotional nature of healthcare work. Interpreters routinely participate in conversations involving serious illness, traumatic injuries, pregnancy loss, end-of-life decisions, family conflict, and life-altering diagnoses. Yet many training programs devote relatively little time to discussing the emotional impact of this work or strategies for managing it. Building awareness of topics such as emotional resilience, vicarious trauma, self-reflection, and professional support systems may better prepare interpreters for the demands of long-term practice.

The findings also challenge educators to think more broadly about cultural mediation. Effective communication often depends on far more than linguistic accuracy. Interpreters described helping bridge differences in expectations, communication styles, family dynamics, and cultural perspectives. This type of work requires curiosity, humility, critical thinking, and the ability to recognize when culture may be influencing an interaction. Educational programs that encourage learners to analyze situations rather than memorize cultural facts may better reflect the realities of contemporary healthcare settings.

Equally important is the growing need for interpreters to function effectively within interdisciplinary healthcare teams. Many participants described collaborating with physicians, nurses, social workers, therapists, and other healthcare professionals. These interactions require communication skills that are rarely discussed in traditional interpreter curricula. Understanding healthcare systems, navigating professional relationships, participating in team-based

environments, and communicating concerns appropriately may become increasingly valuable as healthcare delivery models continue to evolve.

At its core, this study raises an important question for interpreter educators: Are we preparing interpreters for the profession as it is practiced, or for the profession as it is described? The two are not always identical. While linguistic competence remains the foundation of professional interpreting, the experiences shared by participants suggest that success in healthcare settings also depends on judgment, adaptability, self-awareness, communication skills, and the ability to navigate complexity. Educational programs that acknowledge and address these realities may be better positioned to prepare interpreters for the challenges and responsibilities they will encounter throughout their careers.

Implications for Professional Organizations and Certification Bodies

The findings of this study raise important considerations for professional organizations, certification bodies, and other entities that help shape standards within the healthcare interpreting profession. Across all stakeholder groups, interpreters were frequently described as engaging in activities that extended beyond linguistic mediation, including cultural facilitation, communication support, ethical decision-making, patient navigation, and responses to emotionally complex situations. While these responsibilities were not universally viewed as part of the interpreter role, they appeared often enough throughout the data to warrant continued discussion regarding how professional competence is defined, supported, and assessed.

Over the past several decades, the healthcare interpreting profession has made significant progress in establishing standards of practice, codes of ethics, training requirements, and certification pathways. These developments have contributed to increased professionalization

and have helped establish a common foundation for interpreters working in healthcare settings. The findings of this study do not challenge the importance of these efforts. Rather, they suggest that professional competence may encompass dimensions of practice that are difficult to evaluate through traditional measures of language proficiency and interpreting performance alone.

One area deserving particular attention is ethical decision-making. Participants repeatedly described situations involving competing priorities, uncertain outcomes, and circumstances in which multiple professional values appeared equally relevant. In many cases, interpreters were not questioning the importance of ethical standards. Instead, they were attempting to determine how those standards should be applied within situations that lacked clear or straightforward solutions. This distinction is important because it highlights the difference between knowledge of professional ethics and the ability to navigate complex ethical dilemmas in practice.

The findings align with growing scholarship that views healthcare interpreting as a practice profession requiring contextual judgment, reflection, and adaptability (Dean, 2021; Sielen, 2023). From this perspective, professional competence involves more than the accurate transfer of language. It also includes the ability to analyze situations, evaluate competing considerations, and make decisions that support effective communication while maintaining professional accountability. Professional organizations and certification bodies may therefore benefit from continued exploration of how ethical reasoning and contextual decision-making can be fostered throughout an interpreter's career.

The study also highlights the importance of ongoing professional development. Many participants described challenges that are unlikely to be fully addressed through entry-level training alone. Topics such as professional boundaries, emotional resilience, cultural responsiveness, interdisciplinary collaboration, and ethical gray areas often become more

relevant as interpreters gain experience and encounter increasingly complex situations. Continuing education opportunities that encourage discussion, reflection, and analysis of real-world scenarios may help practitioners strengthen these skills over time.

Another consideration involves the way professional success is communicated within the field. Certification examinations appropriately focus on assessing essential competencies such as language proficiency, interpreting skills, and knowledge of professional standards. However, the experiences shared by participants suggest that professional growth continues well beyond initial certification. The development of judgment, confidence, self-awareness, and contextual decision-making often occurs through experience, mentorship, continuing education, and reflective practice. Recognizing these dimensions of professional growth may help create a more comprehensive understanding of expertise within healthcare interpreting.

The findings additionally support ongoing dialogue regarding the evolving role of healthcare interpreters within patient-centered healthcare systems. As healthcare organizations place greater emphasis on communication quality, patient experience, health equity, and interdisciplinary collaboration, interpreters may increasingly find themselves participating in situations that require skills extending beyond language transfer alone. Professional organizations are uniquely positioned to facilitate these conversations by supporting research, encouraging professional dialogue, and creating opportunities for practitioners to examine emerging challenges and opportunities within the field.

Perhaps the most important implication is that the profession continues to evolve. The experiences shared by interpreters, healthcare providers, and patients suggest that healthcare interpreting is not a static practice governed solely by predetermined rules. Instead, it is a dynamic profession shaped by changing healthcare environments, diverse patient populations,

and increasingly complex communication needs. Professional organizations and certification bodies have played a central role in advancing the profession to its current state and will likely continue to influence how healthcare interpreters are prepared to meet the challenges of the future. The findings of this study suggest that supporting ethical reasoning, reflective practice, and contextual decision-making may represent important areas for continued growth as the profession moves forward.

Limitations of the Study

Several limitations should be considered when interpreting the findings of this study.

First, the study relied on voluntary participation and convenience sampling. Participants were recruited through professional organizations, healthcare networks, social media platforms, and professional contacts. As a result, individuals who chose to participate may have had stronger opinions or greater interest in language access and healthcare interpreting than those who did not participate. The sample therefore may not fully represent the experiences and perspectives of all healthcare interpreters, healthcare providers, or patients.

A second limitation involves the distribution of participants across stakeholder groups. Although interpreter participation exceeded initial recruitment goals, the provider and patient samples were considerably smaller. The perspectives shared by healthcare providers and patients offered valuable insight into the research questions; however, the findings should not be interpreted as representative of all providers or all patients with limited English proficiency. Additional research involving larger provider and patient samples may provide a more comprehensive understanding of these perspectives.

The study also relied on self-reported data. Survey responses reflected participants' perceptions, experiences, and recollections rather than direct observation of healthcare encounters. As with all self-reported data, responses may have been influenced by memory, personal interpretation, social desirability, or individual beliefs regarding the role of healthcare interpreters. While perceptions were central to several of the research questions, observational studies may reveal additional insights regarding how interpreters navigate these situations in practice.

Another limitation relates to the patient population included in the study. Patient participants were Spanish-speaking individuals with experience using healthcare interpreters. Their experiences provide important insight into the perspectives of one of the largest limited English proficient populations in the United States; however, findings may not fully reflect the experiences of patients from other linguistic, cultural, or geographic backgrounds. Additional research involving a broader range of language communities may help determine whether similar patterns emerge across different patient populations.

The study was further limited by its focus on healthcare settings within the United States. Language access policies, healthcare systems, interpreter training requirements, and professional expectations vary considerably across countries and healthcare environments. Consequently, the findings may not be directly transferable to international contexts or healthcare systems operating under different regulatory frameworks.

Finally, as a healthcare interpreter, interpreter trainer, and researcher, I brought professional experience and subject matter expertise to this study. This background provided valuable insight into the research topic and informed the development of the study. At the same time, complete separation between researcher experience and interpretation is neither possible

nor expected within qualitative inquiry. To support trustworthiness and rigor, efforts were made throughout the research process to remain attentive to potential bias, consider multiple perspectives, and ground interpretations in the data collected from participants.

Despite these limitations, the study provides a unique examination of healthcare interpreters' contributions beyond linguistic mediation from the perspectives of interpreters, healthcare providers, and patients. The inclusion of multiple stakeholder groups, combined with both quantitative and qualitative data, offers a richer understanding of the complexities surrounding interpreter roles, professional boundaries, and perceptions of value within healthcare settings.

Recommendations for Future Research

This study explored healthcare interpreters' contributions beyond linguistic mediation through the perspectives of interpreters, healthcare providers, and patients. While the findings provide insight into how these contributions are perceived and experienced, they also highlight several areas that warrant further investigation.

One area deserving additional attention is the relationship between interpreter interventions and patient outcomes. Participants frequently described interpreters contributing to communication quality, patient understanding, cultural understanding, emotional support, and healthcare navigation. However, the present study focused on perceptions and experiences rather than measurable clinical outcomes. Future research could examine whether specific interpreter interventions influence outcomes such as patient satisfaction, treatment adherence, healthcare utilization, trust, informed decision-making, or patient safety.

The findings also raise important questions regarding ethical decision-making in healthcare interpreting. Participants consistently described navigating situations involving competing responsibilities, uncertain boundaries, and context-dependent choices. Additional research could explore how interpreters develop ethical reasoning over time, how experienced and novice interpreters approach ethical dilemmas differently, and which educational approaches are most effective in preparing interpreters for complex decision-making. Longitudinal studies may be particularly valuable for understanding how professional judgment evolves throughout a career.

Another promising area involves interpreter integration within healthcare teams. Healthcare providers frequently described consulting interpreters regarding communication challenges, cultural considerations, and patient understanding. These findings suggest that interpreters may occupy different roles depending on organizational culture, staffing models, and workplace expectations. Future studies could examine how various healthcare systems integrate interpreters into clinical teams and whether different models influence communication quality, provider satisfaction, patient experiences, or interpreter job satisfaction.

The role of modality also merits further investigation. Although participants frequently discussed differences between in-person, video remote, and over-the-phone interpreting, the present study was not designed to directly compare modalities. Additional research could explore how modality influences relationship-building, emotional support, communication effectiveness, cultural mediation, and healthcare team collaboration. As healthcare organizations continue to expand remote language access services, a deeper understanding of these differences may help inform future language access strategies.

The patient perspective represents another important opportunity for continued research. While this study included responses from Spanish-speaking patients, additional studies involving larger and more diverse patient populations could provide a broader understanding of how interpreter contributions are experienced across different language communities, healthcare settings, and cultural contexts. Such research may help identify similarities and differences in patient expectations regarding interpreter roles and responsibilities.

Several findings also suggest the value of exploring the emotional dimensions of healthcare interpreting. Participants frequently described involvement in emotionally intense situations involving trauma, grief, serious illness, and end-of-life care. Future research could examine the relationship between these experiences and interpreter wellbeing, resilience, burnout, compassion fatigue, and vicarious trauma. Understanding the factors that contribute to long-term professional sustainability may help inform support systems for interpreters working in demanding healthcare environments.

Finally, the findings raise broader questions regarding how healthcare organizations define and evaluate interpreter value. Existing productivity measures often focus on encounter volume, interpreted minutes, utilization rates, and operational efficiency. Yet participants repeatedly described contributions that were relational, contextual, and difficult to quantify. Additional research examining alternative approaches to measuring interpreter impact may help healthcare organizations better understand the role interpreters play in supporting communication, patient experience, health equity, and quality of care.

The healthcare interpreting profession has undergone substantial growth and professionalization over the past several decades. As healthcare systems continue to evolve and patient populations become increasingly diverse, opportunities exist to deepen our understanding

of how interpreters contribute to communication, patient care, and healthcare delivery. The findings of this study suggest that many of the most significant aspects of interpreter work remain only partially understood, making this an important area for continued scholarly inquiry.

Conclusion

Healthcare interpreters are often described as language conduits whose primary responsibility is to facilitate communication between patients and healthcare providers. While accurate interpretation remains the foundation of professional practice, the findings of this study suggest that such descriptions capture only part of the reality of healthcare interpreting. Across quantitative and qualitative data collected from interpreters, healthcare providers, and patients, participants consistently described contributions that extended beyond linguistic mediation alone. These contributions included facilitating cultural understanding, supporting communication during complex encounters, assisting patients in navigating healthcare systems, contributing to patient comfort and trust, helping prevent misunderstandings, and navigating ethical challenges that arise in the course of patient care.

The findings revealed substantial agreement across stakeholder groups regarding the value of these contributions. Interpreters frequently described engaging in activities that extended beyond direct language transfer, while providers and patients often viewed these contributions as beneficial to communication, patient experience, and healthcare delivery. At the same time, participants acknowledged the complexity of professional boundaries and the ethical tensions that can emerge when patient needs appear to conflict with traditional expectations of neutrality. Rather than describing healthcare interpreting as a profession governed by rigid rules,

participants portrayed a practice that requires judgment, adaptability, and continuous decision-making in response to the realities of individual encounters.

Viewed through the lens of Muted Group Theory, the findings suggest that healthcare interpreters frequently serve as bridges between healthcare systems and patients whose voices may otherwise be constrained by linguistic and cultural barriers. Their work often involves more than conveying messages between languages. Interpreters help make patient concerns visible, facilitate understanding across cultural and linguistic differences, and support communication in situations where misunderstandings may have significant consequences. In doing so, they occupy a unique position within healthcare encounters that allows them to recognize needs, barriers, and concerns that may not always be apparent to others.

A central finding of this study is that many of these contributions remain difficult to measure using traditional indicators of productivity and performance. Healthcare organizations can easily quantify encounter volume, interpreted minutes, and utilization rates. Measuring trust, understanding, cultural responsiveness, communication quality, and the prevention of misunderstandings is considerably more challenging. Yet these were among the contributions most frequently identified by participants as valuable. This disconnect helps explain why many aspects of interpreter work remain hidden despite their importance to patients, providers, and healthcare systems.

The title of this study, *The Hidden Roles of Healthcare Interpreters*, reflects more than the existence of activities beyond linguistic message transfer. It reflects the reality that some of the most meaningful contributions interpreters make occur in moments that are difficult to quantify and often absent from formal role descriptions. Whether helping a frightened patient understand a diagnosis, assisting a provider in navigating a cultural misunderstanding,

supporting communication during a difficult conversation, or helping ensure that a patient's concerns are fully understood, interpreters contribute to healthcare in ways that extend beyond the transfer of words alone.

As healthcare systems continue to prioritize patient-centered care, health equity, and effective communication, a more complete understanding of interpreter contributions becomes increasingly important. Recognizing the full scope of interpreter work does not diminish the importance of linguistic accuracy or professional boundaries. Rather, it acknowledges the complexity of healthcare communication and the essential role interpreters play in making healthcare accessible, understandable, and equitable for linguistically diverse populations. The findings of this study suggest that healthcare interpreters are not simply facilitating communication. They are helping shape the conditions that make meaningful communication, informed decision-making, and equitable care possible.

References

Alarcon, L. N., Ewen, A. M., Acuña-Martinez, E., & Cheston, C. C. (2024). Improving communication with patients with limited English proficiency: Non-English language proficiency assessment for clinicians. *The Joint Commission Journal on Quality and Patient Safety, 50*(1), 83–86. https://doi.org/10.1016/j.jcjq.2023.08.007

Allison, M. T., & Hibbler, D. K. (2004). Organizational barriers to inclusion: Perspectives from the recreation professional. *Leisure Sciences*, 26(3), 261–280. https://doi.org/10.1080/01490400490461396

Álvaro Aranda, C. (2020). Analysing the healthcare interpreter's role in the "in-between": An exploratory study of patient-interpreter spoken interactions in a hospital setting. *SKASE Journal of Translation and Interpretation, 13*(2), 22–37. http://www.skase.sk/Volumes/JTI19/pdf_doc/02.pdf

Álvaro Aranda, C. (2021). “I don't know, I'm just the interpreter”: A first approach to the role of healthcare interpreters beyond bilingual medical encounters. *TRANS. Revista de Traductología, 25*, 395–412. https://revistas.uma.es/index.php/trans/en/article/view/10128

Angelelli, C. V. (2004). *Revisiting the interpreter's role: A study of conference, court, and medical interpreters in Canada, Mexico, and the United States*. John Benjamins Publishing Company. https://doi.org/10.1075/btl.55

Angelelli, C. V. (2004). *Medical Interpreting and Cross-cultural Communication*. Cambridge: Cambridge University Press.

Angelelli, C., & Degueldre, C. (2019). *Healthcare interpreting explained*. Routledge. https://doi.org/10.4324/9781315310978.

Ardener, S. (2005). Ardener's "muted groups": The genesis of an idea and its praxis. *Women and Language*, *28*(2), 50–54.

Arocha, I. S., & Joyce, L. (2013). Patient safety, professionalization, and reimbursement as primary drivers for national medical interpreter certification in the United States. *Translation & Interpreting, 5*(1), 127–142. https://trans-int.org/index.php/transint/article/view/206

Barkman, L. L. S. (2018). Muted group theory: A tool for hearing marginalized voices. *Priscilla Papers*, *32*(4), 3–7. https://www.cbeinternational.org/resource/muted-group-theory-tool-hearing-marginalized-voices/

Barwise, A., & Pickering, B. (2022). The AI needed for ethical decision making does not exist. *American Journal of Bioethics, 22*(7), 46–49. https://doi.org/10.1080/15265161.2022.2075052

Beltran Avery, M.-P. (2001). *The role of the health care interpreter: An evolving dialogue*. National Council on Interpreting in Health Care. https://www.ncihc.org/assets/documents/publications/NCIHC%20Working%20Paper%20-%20Role%20of%20the%20Health%20Care%20Interpreter.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Castro, M. R. H., Schwartz, H., Hernandez, S., Calthorpe, L., Fernández, A., Stein, D., Mackersie, R. C., Menza, R., & Bongiovanni, T. (2022). The association of limited English proficiency with morbidity and mortality after trauma. *Journal of Surgical Research, 280*, 326–332. https://doi.org/10.1016/j.jss.2022.07.044

California Healthcare Interpreting Association. (2017). *California standards for healthcare interpreters: Ethical principles, protocols, and guidance on roles and intervention* (Rev. ed.). California Healthcare Interpreting Association. https://chiaonline.org/CHIA-Standards

Certification Commission for Healthcare Interpreters. (2016). *National job task analysis study for healthcare interpreters*. CCHI. Retrieved from https://cchicertification.org/uploads/CCHI_JTA2016_Report.pdf

Certification Commission for Healthcare Interpreters. (2022). *CCHI job analysis report 2022.* Prometric. Retrieved from https://cchicertification.org/uploads/CCHI_Job_Analysis_Report_2022.pdf

Certification Commission for Healthcare Interpreters. (2024). *Candidate's examination handbook: Core Certification Healthcare Interpreter™ (CoreCHI™), CoreCHI-Performance™ (CoreCHI-P™), and Certified Healthcare Interpreter™ (CHI™).* https://cchicertification.org

Chipman, S. A., Meagher, K., & Barwise, A. K. (2024). A public health ethics framework for populations with limited English proficiency. *The American Journal of Bioethics, 24*(11), 50–65. https://doi.org/10.1080/15265161.2023.2224263

Crane, E. (2022). *Soft skills: Adding the human component to curricula* [Master's thesis, Western Oregon University]. https://wou.omeka.net/s/repository/item/4506

Data USA. (2024). *Interpreters and translators*. https://datausa.io/profile/soc/interpreters-and-translators

Davidson, B. (2000). The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics, 4*(3), 379–405. https://doi.org/10.1111/1467-9481.00121

Dean, R. K. (2014). Condemned to repetition? An analysis of problem-setting and problem-solving in sign language interpreting ethics. *Translation & Interpreting, 6*(1), 60–75. https://doi.org/10.12807/ti.106201.2014.a04

Dean, R. K. (2021). Reflection-in-action: Measuring context in medical interpreting. *Linguistica Antverpiensia, New Series: Themes in Translation Studies, 20*, 248–266. https://doi.org/10.52034/lanstts.v20i.608

Dean, R. K., & Pollard, R. Q. (2011). Context-based Ethical Reasoning in Interpreting: A Demand Control Schema Perspective. *The Interpreter and Translator Trainer*, *5*(1), 155–182. https://doi.org/10.1080/13556509.2011.10798816

Dysart-Gale, D. (2005). Communication Models, Professionalization, and the Work of Medical Interpreters. *Health Communication*, *17*(1), 91–103. https://doi.org/10.1207/s15327027hc1701_6

Espinoza, J., & Derrington, S. (2021). How should clinicians respond to language barriers that exacerbate health inequity? *AMA Journal of Ethics, 23*(2), E109–E116. https://doi.org/10.1001/amajethics.2021.109

Flores, G., Abreu, M., Barone, C. P., Bachur, R., & Lin, H. (2012). Errors of medical interpretation and their potential clinical consequences: A comparison of professional versus ad hoc versus no interpreters. *Annals of Emergency Medicine, 60*(5), 545–553. https://doi.org/10.1016/j.annemergmed.2012.01.025

Giglio, M. E., Pelton, M., Yang, A. L., Patel, A., Buzzelli, L. K., Schick, J., Ssentongo, A., Tian, Z., Ryan, C. A., Razavi, N., & Fredrick, B. (2022). COVID-19 contact tracing highlights disparities: Household size and low-English proficiency. *Health Equity, 6*(1), 330–333. https://doi.org/10.1089/heq.2021.0148

Goler, E., & Mack, J. W. (2024). Ethical Tensions in the Role of the Medical Interpreter. *Narrative inquiry in bioethics*, *14*(3), 189–193. https://doi.org/10.1353/nib.2024.a947860

Hempel, S., Larkin, J., Pincus, H. A., Rubenstein, L. V., Stockdale, S. E., & Smith, S. N. (2021). *Primary care productivity: Findings from the literature and stakeholder discussions* (RR-A703-1). RAND Corporation. https://doi.org/10.7249/RRA703-1

Herring, R. E. (2018). *I could only think about what I was doing, and that was a lot to think about: Online self-regulation in dialogue interpreting* [Doctoral dissertation, Université

de Genève]. https://archiveouverte.unige.ch/unige:108626:contentReference[oaicite:0]{index=0}

Hsieh E. (2008). "I am not a robot!" Interpreters' views of their roles in health care settings. *Qualitative health research*, *18*(10), 1367–1383. https://doi.org/10.1177/1049732308323840

Hsieh, E., Ju, H., & Kong, H. (2010). Dimensions of trust: The tensions and challenges in provider-interpreter trust. *Qualitative Health Research, 20*(2), 170–181. https://doi.org/10.1177/1049732309349935

Hsieh, E., & Kramer, E. M. (2012). Medical interpreters as tools: dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient educations and counseling, 89*(1), 158-162. https://doi.org/10.1016/j.pec.2012.07.001

International Medical Interpreters Association. (2008). *Code of ethics for medical interpreters* (Originally established 1987; revised 2006). https://imiaweb.org/uploads/pages/376.pdf

International Medical Interpreters Association, & Education Development Center, Inc. (1995). *Medical interpreting standards of practice*. International Medical Interpreters Association. https://www.imiaweb.org/uploads/pages/102.pdf

Joseph, C., Garrubba, M., & Melder, A. (2018). Patient satisfaction of telephone or video interpreter services compared with in-person services: A systematic review. *Australian Health Review, 42*(2), 168–177. https://doi.org/10.1071/AH16195

Karliner, L. S., Pérez-Stable, E. J., & Gregorich, S. E. (2017). Convenient access to professional interpreters in the hospital decreases readmission rates. *Medical Care, 55*, 199–206. https://doi.org/10.1097/MLR.0000000000000643

Kramarae, C. (2005). Muted group theory and communication: Asking dangerous questions. *Women and Language*, *28*(2), 55–61.

Kwan, M., Jeemi, Z., Norman, R., & Dantas, J. A. R. (2023). Professional interpreter services and the impact on hospital care outcomes: An integrative review of literature. *International Journal of Environmental Research and Public Health, 20*(6), 5165. https://doi.org/10.3390/ijerph20065165

Latif, Z., Kontrimas, J., & Warraich, H. J. (2024). Working With Medical Interpreters. *JAMA*, 10.1001/jama.2024.20900. Advance online publication. https://doi.org/10.1001/jama.2024.20900

Lindholm, M., Hargraves, J. L., Ferguson, W. J., & Reed, G. (2012). Professional language interpretation and inpatient length of stay and readmission rates. *Journal of General Internal Medicine, 27*, 1294–1299. https://doi.org/10.1007/s11606-012-2041-5

Major, G., & Napier, J. (2019). “I'm there sometimes as a just in case”: Examining role fluidity in healthcare interpreting. In M. Ji, M. O'Hagan, & M. Oakes (Eds.), *Multicultural health translation, interpreting and communication* (Chapter 9, pp. 183–204). Routledge. https://doi.org/10.4324/9781351000390

Meyer, S. B., Brown, P., Calnan, M., Ward, P. R., Little, J., Betini, G. S., Perlman, C. M., Burns, K. E., & Filice, E. (2024). Development and validation of the Trust in Multidimensional

Healthcare Systems Scale (TIMHSS). *International Journal for Equity in Health, 23*, Article 94. https://doi.org/10.1186/s12939-024-02162-y

Mikkelson, H. (2015). Review of *Redefining the role of the community interpreter: The concept of "role-space,"* by P. Llewellyn-Jones and R. G. Lee. *Interpreting, 17*(2), 284–289. https://doi.org/10.1075/intp.17.2.06mik

Naeem, M., Ozuem, W., Howell, K., & Ranfagni, S. (2023). A step-by-step process of thematic analysis to develop a conceptual model in qualitative research. *International Journal of Qualitative Methods, 22*, 1–18. https://doi.org/10.1177/16094069231205789

National Association of Judiciary Interpreters and Translators. (n.d.). *Code of ethics and professional responsibilities*. https://najit.org/wp-content/uploads/2016/09/NAJITCodeofEthicsFINAL.pdf

National Council on Interpreting in Health Care. (2004). *A national code of ethics for interpreters in health care*. https://www.ncihc.org/assets/z2021Images/NCIHC%20National%20Code%20of%20Ethics.pdf

National Council on Interpreting in Health Care. (2005). *National standards of practice for interpreters in health care*. https://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf

National Council on Interpreting in Health Care. (2021). *Interpreter advocacy in healthcare encounters: A closer look*.

https://www.ncihc.org/assets/z2021Images/Interpreter%20Advocacy%20in%20Healthcare%20Encounters%20A%20Closer%20Look%20F051121.pdf

Nguyen, Q., Flora, J., Basaviah, P., Bryant, M., Hosamani, P., Westphal, J., Kugler, J., Hom, J., Chi, J., Parker, J., & DiGiammarino, A. (2024). Interpreter and limited-English proficiency patient training helps develop medical and physician assistant students' cross-cultural communication skills. *BMC Medical Education, 24*, Article 185. https://doi.org/10.1186/s12909-024-05173-z

Ortega, P., Shin, T. M., & Martínez, G. A. (2022). Rethinking the Term "Limited English Proficiency" to Improve Language-Appropriate Healthcare for All. *Journal of immigrant and minority health*, *24*(3), 799–805. https://doi.org/10.1007/s10903-021-01257-w

Plys, E., Giraldo-Santiago, N., Ehmann, M., Brewer, J., Presciutti, A. M., Rush, C., McDermott, K., Greenberg, J., Ritchie, C., & Vranceanu, A. M. (2024). "They really trust us!": Medical Interpreter's Roles and Experiences in an Integrated Primary Care Clinic. *Social work in mental health*, *22*(5), 715–733. https://doi.org/10.1080/15332985.2024.2379455

Pyle, J. W. (2025). *The rhetorical disengagement phenomenon of quiet quitting in organizational behavior: Harmful leadership, muteness and power* [Doctoral dissertation, The University of Alabama]. https://ir.ua.edu/handle/123456789/16984

Registry of Interpreters for the Deaf, & National Association of the Deaf. (2005). *Code of professional conduct*. https://rid.org/ethics/code-of-professional-conduct/

Rusho, D. (2023). First Nations interpreters cannot be neutral and should not be invisible. *Translation & Interpreting, 15*(1), 120–134. https://doi.org/10.12807/ti.115201.2023.a06

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. Basic Books.

Sielen, E. J. (2023). *Learning on the job: A professional and ethical profile of Washington State interpreters* [Master's thesis, Western Oregon University]. https://wou.omeka.net/s/repository/item/13472

Suarez, N. R. E., Urtecho, M., Jubran, S., Yeow, M. E., Wilson, M. E., Boehmer, K. R., & Barwise, A. K. (2021). The Roles of medical interpreters in intensive care unit communication: A qualitative study. *Patient education and counseling*, *104*(5), 1100–1108. https://doi.org/10.1016/j.pec.2020.10.018

Sultanić, I. (2018). *Medical interpreter training and interpreter readiness for the hospital environment* [Doctoral dissertation, Kent State University]. https://www.proquest.com/openview/

Syawal, M. S., Dwiandini, A., Khaerunnisa, D. H., & Irwansyah. (2024). Exploring the role of muted group theory in understanding women's experiences: A systematic literature review. *International Journal of Humanity Studies*, *7*(2), 279–294. https://doi.org/10.24071/ijhs.v7i2.7305

Taira, B. R., & Orue, A. (2019). Language assistance for limited English proficiency patients in a public ED: Determining the unmet need. *BMC Health Services Research, 19*, Article 56. https://doi.org/10.1186/s12913-018-3823-1

Teisberg, E., Wallace, S., & O'Hara, S. (2020). Defining and implementing value-based health care: A strategic framework. *Academic Medicine, 95*(5), 682–685. https://doi.org/10.1097/ACM.0000000000003122

U.S. Department of Health and Human Services, Office for Civil Rights. (2016). *Letter of finding: University of New Mexico Hospital*. https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/examples/limited-english-proficiency/unm-letter-of-finding/index.html

U.S. Department of Justice. (2024, August 22). *DOJ and U.S. Health and Human Services settle claims that MultiCare Health System violated federal civil rights laws by failing to provide language services*. https://www.justice.gov/usao-wdwa/pr/doj-and-us-health-and-human-services-settle-claims-multicare-health-system-violated

Wadensjö, C. (1998). *Interpreting as interaction*. Longman.

Witter-Merithew, A. (1999). *From benevolent caretaker to ally: The evolving role of the sign language interpreter*. http://www.interpretereducation.org/wp-content/uploads/2014/04/From-Benevolent-Caretaker.pdf

Youdelman, M. (2013). The development of certification for healthcare interpreters in the United States. *Translation & Interpreting, 5*(1), 114–125. https://trans-int.org/index.php/transint/article/view/205

Youdelman, M. (2024). *What is required under Title VI and Section 1557 to ensure language access for individuals with limited English proficiency?* National Health Law Program. Retrieved March 11, 2025, from https://healthlaw.org/resource/what-is-required-under-title-vi-and-section-1557-to-ensure-language-access-for-individuals-with-limited-english-proficiency/

Yuan, X. (2022). A symbolic interactionist approach to interpreter's identity management. *Interpreting and Society: An Interdisciplinary Journal, 2*(2), 141–159. https://doi.org/10.1177/27523810221100990

Appendix A: Survey Instruments

Medical Interpreter Survey

Medical Interpreter Survey - The Hidden Roles of Medical Interpreters Research Project

Introduction

This survey explores the various roles medical interpreters play in healthcare settings, particularly activities performed in addition to interpreting. To participate in this survey, you must be a practicing medical interpreter with experience providing interpreting services in healthcare settings. Your participation will improve understanding of interpreter contributions to limited English proficient (LEP) patient care. The survey takes approximately 20-30 minutes to complete. All responses are anonymous.

About Professional Standards: The National Council on Interpreting in Health Care (NCIHC) is a professional organization that developed national standards for medical interpreters. These standards are widely used in training programs and by healthcare institutions. Do not worry if you are not familiar with them, your experience and perspective are valuable regardless of your training background.

Definitions for this survey:

- **Advocacy**: When interpreters speak out to protect patients from serious harm or mistreatment.
- **Cultural awareness**: The expectation that interpreters are familiar with their LEP patient population's culture and alert healthcare providers to possible cultural misunderstandings
- **Cultural connection**: Shared understanding based on similar cultural or linguistic backgrounds.
- **Emotional support**: Providing comfort, reassurance, or understanding in addition to interpreting medical information.
- **Professional boundaries**: Formal guidelines that define an interpreter's role and responsibilities, ensuring that the interpreter carries out only the duties appropriate to the interpreting role and does not assume tasks, relationships, or responsibilities that fall outside of that scope.
- **Tasks beyond interpreting**: Any actions taken by interpreters during an encounter that go beyond the accurate and impartial transfer of spoken or signed messages between parties, including assuming roles, responsibilities, or interactions not inherent to the interpreting function, such as providing opinions or advice, engaging in decision-making or advocacy, performing administrative or clinical tasks, or responding directly to the emotional expressions or needs of patients, family members, or providers.
- **Other**: Any additional concepts, activities, or situations not covered by the above definitions.

Section A: Background Information

1. What is your age range? ☐ 18–29 ☐ 30–39 ☐ 40–49 ☐ 50–59 ☐ 60 or older ☐ Prefer not to answer

2. What is your gender identity? ☐ Female ☐ Male ☐ Non-binary ☐ Other: _____ ☐ Prefer not to answer

3. What is your primary working language other than English? (check all that apply) ☐ Arabic ☐ ASL ☐ Mandarin ☐ Russian ☐ Somali ☐ Spanish ☐ Vietnamese ☐ Other: _____

4. How many years of experience do you have working as a medical interpreter? ☐ Less than 1 year ☐ 1–3 years ☐ 4–7 years ☐ 8–12 years ☐ 13 or more years

Section B: Interpreting Experience

5. Which of the following options best describes your employment type? ☐ Healthcare institution employee ☐ Language services provider/company (LSP) employee ☐ Independent contractor/freelancer ☐ Dual role (e.g., nurse who also interprets) ☐ Other: _____

6. What types of interpreting services do you provide? (check all that apply) ☐ In-person ☐ Video Remote Interpreting (VRI) ☐ Over-the-Phone Interpreting (OPI)

7. If you work in multiple modalities, estimate the percentage of time you interpret in each modality: In-person: _____% | VRI: _____% | OPI: _____% ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

8. Do you notice differences in how you can support limited English proficient (LEP) patients based on the interpreting modality? ☐ Yes, significant differences ☐ Yes, some differences ☐ No differences ☐ Haven't noticed

9. In your opinion, which factors are essential for you to provide quality care to LEP patients? (check all that apply) ☐ Being physically present in the room ☐ Being able to see the patient ☐ High language proficiency level ☐ Your skill/experience level ☐ Your understanding of US healthcare system ☐ Your familiarity with medical terminology ☐ Good audio/video quality ☐ Having adequate time allotted for the session ☐ Being included in care discussions ☐ Cultural knowledge of patient's background ☐ Ability to prepare before assignments ☐ Working with healthcare providers who have received training on how to work with medical interpreters ☐ Other : _____

10. When do you find yourself most able to assist patients with tasks other than interpreting? (check all that apply) ☐ When you can see the patient ☐ When you are in the same room as the patient ☐ When interpreting remotely by video ☐ When interpreting over-the-phone ☐ When you have more time with the patient after the encounter ☐ When providers include you in discussions ☐ Other : _____

Section C: Medical Specialties and Interpreter Education

11. In what clinical settings do you work? (check all that apply) ☐ Hospital ☐ Outpatient clinic ☐ Other: _____

12. How many different medOther:ialties do you interpret for regularly? (e.g., obstetrics/gynecology, internal medicine, emergency medicine, endocrinology, etc.) ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 10 or more

13. What is your national interpreter certification status? (check all that apply) ☐ CDI ☐ CHI-Arabic ☐ CHI-Mandarin ☐ CHI-Spanish ☐ CMI-Korean ☐ CMI-Mandarin ☐ CMI-Russian ☐ CMI-Spanish ☐ CMI-Vietnamese ☐ CoreCHI ☐ CoreCHI-P ☐ Hub-CMI ☐ NIC ☐ Not certified

14. What is the highest level of interpreter training you have completed? ☐ No formal training ☐ Self-study ☐ On-the-job training only ☐ 40+ hour medical interpreter training program ☐ College/university certificate program in interpreting ☐ Bachelor's degree in interpreting ☐ Master's in interpreting ☐ PhD in interpreting ☐ Other : _____

15. What is the highest level of education you have complOther: High school diploma/GED ☐ Some college ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ PhD/Doctoral degree ☐ Prefer not to answer

Section D: Activities Beyond Interpreting

16. When you notice potential communication issues during an encounter, what influences when you decide to intervene? (Check all that apply)

A) ☐ Potential consequences if misunderstanding continues

B) ☐ Patient's level of distress or confusion

C) ☐ Provider's confidence level

D) ☐ Medical urgency of the situation

E) ☐ Gut feeling that something is wrong

F) ☐ Patient's body language or nonverbal cues

G) ☐ Previous experience with similar situations

H) ☐ Time available for the appointment

I) ☐ Your rapport with the patient or provider

J) ☐ Other: _____

17. Look back at your answers in Q11. Of those factors you checked, rank your TOP 3 by selecting the corresponding letters below:

Most important: _____ (write letter: A, B, C, etc.)

Second most important: _____

Third most important: _____

18. How often do you intervene based on instinct before fully analyzing the situation? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

19. Do you ever realize afterward that you considered factors you were not initially aware of when deciding to intervene? ☐ Yes, frequently ☐ Yes, occasionally ☐ Rarely ☐ Never ☐ Not sure

20. Professional guidelines suggest interpreters should only perform tasks within the interpreter's role. However, have you ever been in situations where a provider wasn't available and you assisted a patient directly with tasks instead of or in addition to interpreting? For each item below, indicate if you do this and how often:

For frequency: Never=1, Rarely=2, Sometimes=3, Often=4, Always=5

Scheduling appointments or follow-up visits: Do this? ☐ Yes ☐ No | If yes - Frequency: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Explaining medical procedures or referral processes: Do this? ☐ Yes ☐ No | If yes - Frequency: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Providing logistical information (transportation, resources, navigation): Do this? ☐ Yes ☐ No | If yes - Frequency: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Answering insurance or billing questions: Do this? ☐ Yes ☐ No | If yes - Frequency: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Advocating for patient needs: Do this? ☐ Yes ☐ No | If yes - Frequency: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Providing emotional support or comfort: Do this? ☐ Yes ☐ No | If yes - Frequency: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Providing a cultural explanation or mediation: Do this? ☐ Yes ☐ No | If yes - Frequency: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

21. If you have ever provided direct assistance to a patient in a way that was not included in the options to the previous question, please explain:

Section E: Emotional Support and Cultural Connection

22. Professional interpreting guidelines suggest limiting personal involvement with patients. However, have you ever provided emotional support to patients during difficult medical situations? ☐ Yes, frequently ☐ Yes, occasionally ☐ Rarely ☐ Never

23. If you answered yes to the previous question, in what circumstances have you provided this support? (check all that apply)

A) ☐ When no healthcare staff were immediately available

B) ☐ When the patient was alone and distressed

C) ☐ When delivering difficult news

D) ☐ During frightening procedures

E) ☐ When culturally appropriate care was needed

F) ☐ Other: _____

24. Look back at your answers in Q14. Of those circumstances you checked, rank your TOP 3 by selecting the corresponding letters below:

Most likely: _____ (write letter: A, B, C, etc.)

Second most likely: _____

Third most likely: _____

25. When you provide emotional support, how do you justify this in relation to professional interpreting guidelines? (Check all that apply) ☐ You view this as cultural interpreting ☐ You consider it advocacy for patient safety/wellbeing ☐ You consider it basic human compassion ☐ I do not provide emotional support to patients ☐ Guidelines don't address these real situations ☐ You struggle with this conflict ☐ Other: _____

26. What responsibilities do you believe should be included in a medical interpreter's role?

27. Do you believe providing compassionate support to patients should be considered an ethical interpreting practice? ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

28. Please explain your reasoning:

29. How often are you the only person on the healthcare team who is familiar with the patient's cultural background or understands their cultural nuances? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

30. If you are the only person familiar with the patient's culture, please describe how this affects your interactions:

31. How often do you alert healthcare providers to cultural misunderstandings that may affect patient care? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Section F: Critical Decision-Making

32. Have you ever encountered situations where you felt you could support a patient but weren't sure if you should due to professional interpreting guidelines? ☐ Yes ☐ No

33. How often does this happen? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very often

34. How conflicted do you typically feel in these situations? ☐ Not conflicted ☐ Slightly conflicted ☐ Moderately conflicted ☐ Very conflicted ☐ Extremely conflicted

35. Which situations have created this conflict for you? (Check all that apply)

A) ☐ Patient received difficult news and had no support person present

B) ☐ Patient agreed to something you suspected they didn't understand

C) ☐ Patient sought physical comfort during a frightening procedure

D) ☐ Patient asked you to stay for emotional support during serious decisions

E) ☐ Patient was being discharged without adequate understanding/resources

F) ☐ None of these

G) ☐ Other: _____

36. Look back at your answers to the previous question. Of those situations you checked, rank your TOP 3 by selecting the corresponding letters below:

Most conflict: _____ (write letter: A, B, C, etc.)

2nd most conflict: _____

3rd most conflict: _____

37. Please describe a specific situation where you performed tasks that went beyond interpreting and what happened as a result:

38. In these situations, what usually influences your decision about whether to act? (Check all that apply) ☐ Potential consequences for the patient ☐ Risk of violating professional boundaries ☐ Whether other staff are available to assist the patient ☐ Patient's level of distress ☐ Your relationship with the healthcare provider/team ☐ Other: _____

39. How do you typically decide when to support patients beyond interpreting?

40. How often do you feel tension between professional guidelines about staying within interpreting boundaries and situations where you could support a patient? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

41. If you've encountered this tension, how do you typically resolve these conflicts?

Section G: Team Integration and Collaboration

42. How often do healthcare providers consult with you about cultural considerations? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

43. How often do healthcare providers consult with you about linguistic considerations? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

44. If providers consult with you, how often do they use your suggestions? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always ☐ Not applicable (providers don't consult me)

45. Have you been involved in providing training to healthcare providers about working with interpreters or LEP patients? ☐ Yes ☐ No

46. If yes, what types of training have you provided? (check all that apply) ☐ Orientation sessions for new healthcare staff ☐ In-service training for existing healthcare providers ☐ 40+ hour medical interpreter training programs ☐ Conference presentations or workshops ☐ Cultural competency training ☐ Grand rounds presentations ☐ Educational initiatives within your institution ☐ One-on-one mentoring or guidance ☐ In-house interpreter training sessions ☐ Training for specific specialties (ICU, ED, etc.) ☐ Online training modules or materials ☐ Training other interpreters ☐ College or university courses ☐ Community education programs ☐ Other : _____

Section H: Professional Confidence and Knowledge

47. How do you think you contribute to patient outcomes? ☐ Primarily through language interpreting ☐ Through both language interpreting and tasks beyond interpreting ☐ I'm not sure ☐ Other: _____

48. Please explain your reasoning:

49. How confident are you in your ability to maintain professional interpreting ethics while providing emotional support to patients? ☐ Not at all confident ☐ Slightly confident ☐ Somewhat confident ☐ Confident ☐ Very confident

50. How familiar are you with formal professional interpreting ethics and standards for medical interpreters? ☐ Very familiar ☐ Somewhat familiar ☐ Slightly familiar ☐ Not at all familiar

51. If applicable, what guidance or training would assist you in navigating situations where you could support patients beyond interpreting?

Closing Question

52. Now that you have completed this survey, what else would you like to share with me about your experience as a medical interpreter?

Thank you for your participation! Your responses will improve understanding of the important roles medical interpreters play in healthcare settings.

If you have any questions about this study, please contact Marisa Rueda Will at mruedawill24@mail.wou.edu.

Healthcare Provider Survey

Healthcare Providers Survey - The Hidden Roles of Medical Interpreters Research

Introduction

This survey explores healthcare providers' perspectives on medical interpreter roles, particularly activities beyond language interpreting. To participate in this survey, you must be a practicing healthcare provider with experience working with medical interpreters and LEP (Limited English Proficient) patients. Your participation will improve understanding of interpreter contributions to patient care and team collaboration. The survey takes approximately 15-20 minutes to complete. All responses are confidential.

About Professional Standards: Medical interpreters follow professional guidelines developed by organizations like the National Council on Interpreting in Health Care (NCIHC). These guidelines generally suggest interpreters should limit their activities to language interpreting only. Your experiences working with interpreters will help us understand how these guidelines apply in real healthcare situations.

Definitions for this survey:

- **Cultural mediation**: When medical interpreters intervene to alert healthcare providers to possible cultural misunderstandings
- **Emotional support**: Providing comfort, reassurance, or understanding in addition to interpreting medical information.
- **LEP patients**: Limited English Proficient patients who need interpreter services.
- **Professional boundaries**: Formal guidelines that define an interpreter's role and responsibilities, ensuring that the interpreter carries out only the duties appropriate to the interpreting role and does not assume tasks, relationships, or responsibilities that fall outside of that scope.
- **Tasks beyond interpreting**: Any actions taken by interpreters during an encounter that go beyond the accurate and impartial transfer of spoken or signed messages between parties, including assuming roles, responsibilities, or interactions not inherent to the interpreting function, such as providing opinions or advice, engaging in decision-making or advocacy, performing administrative or clinical tasks, or responding directly to the emotional expressions or needs of patients, family members, or providers.
- **Other**: Any additional concepts, activities, or situations not covered by the above definitions

Section A: Background Information

1. What is your age range? ☐ 18–29 ☐ 30–39 ☐ 40–49 ☐ 50–59 ☐ 60 or older ☐ Prefer not to answer

2. What is your gender identity? ☐ Female ☐ Male ☐ Non-binary ☐ Other: _____ ☐ Prefer not to answer

3. What is your professional role? ☐ Physician ☐ Nurse Practitioner ☐ Physician Assistant ☐ Nurse ☐ Social Worker ☐ Other (please specify): _____

4. How many years of experience do you have working with LEP patients? ☐ Less than 1 year ☐ 1–3 years ☐ 4–7 years ☐ 8–12 years ☐ 13 or more years

Section B: Interpreting Experience

5. How often do you work with medical interpreters? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Monthly ☐ Rarely

6. What type of interpreter services do you receive? (check all that apply) ☐ In-person interpreting ☐ Video Remote Interpreting (VRI) ☐ Over-the-Phone Interpreting (OPI) ☐ Bilingual staff members

7. If you receive interpreting services in multiple modalities, estimate the percentage of the time you work with each modality: In-person: _____% | VRI: _____% | OPI: _____% | Bilingual Staff Members: _____% ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

8. What are the credentials required of staff healthcare interpreters employed by your institution? (check all that apply) ☐ National certification for spoken language interpreters (CCHI or NBCMI certification) ☐ National certification for American Sign Language interpreters (CDI, NIC, RID) ☐ 40+ hour medical interpreter training program ☐ Language proficiency testing ☐ Background checks ☐ On-the-job training ☐ HIPAA training ☐ Not sure

9. What are the credentials required of third-party interpreting vendors serving patients in your institution? (check all that apply) ☐ National certification for spoken language interpreters (CCHI or NBCMI certification) ☐ National certification for American Sign Language interpreters (CDI, NIC, RID) ☐ 40+ hour medical interpreter training program ☐ Language proficiency testing ☐ Background checks ☐ On-the-job training ☐ HIPAA training ☐ Not sure

10. What are the credentials required of ad hoc or bilingual staff members serving as interpreters in your institution? ☐ National certification for spoken language interpreters (CCHI or NBCMI certification) ☐ National certification for American Sign Language interpreters (CDI, NIC, RID) ☐ 40+ hour medical interpreter training program ☐ Language proficiency testing ☐ Background checks ☐ On-the-job training ☐ HIPAA training ☐ Not sure

11. What is your primary work setting? ☐ Hospital ☐ Outpatient clinic ☐ Emergency Department ☐ Urgent care ☐ Other: _____

12. What is your medical specialty area? ☐ Emergency Medicine ☐ Primary care/Family Medicine ☐ Internal Medicine ☐ Pediatrics ☐ Surgery ☐ Mental/Behavioral Health ☐ Cardiology ☐ Other (please specify): _____

13. How familiar are you with professional guidelines for medical interpreters? ☐ Very familiar ☐ Somewhat familiar ☐ Slightly familiar ☐ Not familiar ☐ Never heard of any

Section C: Activities Beyond Interpreting

14. Have you observed interpreters stepping in to assist when you or the patient were having difficulty communicating? ☐ Yes, frequently ☐ Yes, occasionally ☐ Rarely ☐ Never

15. When you've observed interpreters stepping in, what seemed to trigger their assistance? (check all that apply)

A) ☐ Patient appeared confused or distressed

B) ☐ Healthcare provider seemed to be struggling with communication

C) ☐ Cultural misunderstanding was apparent

D) ☐ Medical urgency required immediate clarity

E) ☐ Patient asked interpreter directly for help

F) ☐ Complex medical information needed explanation

G) ☐ Patient was alone and seemed to need support

H) Never observed an interpreter stepping in to provide assistance

I) ☐ Other (please specify): _____

16. Look back at your answers to the previous question. Of those triggers you checked, rank your TOP 3 by writing the letters below:

Most common: _____ (write letter: A, B, C, etc.)

2nd most common: _____

3rd most common: _____

17. Have you observed interpreters assist patients directly with tasks beyond interpreting? ☐ Yes ☐ No

18. If yes, which activities have you observed? (check all that apply)

A) ☐ Scheduling appointments or follow-up visits

B) ☐ Explaining medical procedures or next steps

C) ☐ Providing transportation or resource information

D) ☐ Assisting with insurance or billing questions

E) ☐ Advocating for patient needs

F) ☐ Providing emotional support or comfort

G) ☐ Cultural explanation or mediation

H) ☐ Other (please specify): _____

19. Look back at your answers to the previous question. Of those activities you checked, rank your TOP 3 by writing the letters below:

Most frequently observed: _____ (write letter: A, B, C, etc.)

2nd most frequent: ____

3rd most frequent: _____

20. When you've observed these activities, how did they affect patient care? ☐ Very beneficial ☐ Somewhat beneficial ☐ No impact ☐ Somewhat problematic ☐ Very problematic ☐ Never observed these activities

21. How comfortable are you when interpreters provide assistance beyond interpreting? ☐ Very comfortable ☐ Somewhat comfortable ☐ Neutral ☐ Somewhat uncomfortable ☐ Very uncomfortable

Section D: Team Integration and Collaboration

22. Professional guidelines suggest interpreters should limit personal involvement with patients. However, have you ever observed interpreters providing emotional support to patients during difficult situations? ☐ Yes, frequently ☐ Yes, occasionally ☐ Rarely ☐ Never

23. Do you consult with interpreters about cultural considerations for patient care? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

24. Do you observe interpreters providing emotional support to LEP patients? ☐ Yes ☐ No

25. If yes, what types of emotional support have you observed? (check all that apply) ☐ Comforting patients during difficult news ☐ Staying with patients during frightening procedures ☐ Providing reassurance in the patient's language ☐ Offering cultural comfort and understanding ☐ Helping patients feel less alone ☐ Other (please specify): _____

26. Please provide a specific example of emotional support you've observed.

27. How do you view interpreters providing emotional support to patients? ☐ Essential part of their role ☐ Helpful but not required ☐ Acceptable in some situations ☐ Should be avoided ☐ Unprofessional

28. Do you consider interpreters to be part of your healthcare team? ☐ Yes, definitely ☐ Yes, somewhat ☐ Not sure ☐ No, not really ☐ No, definitely not

29. As a healthcare professional, how do you view providing emotional support to patients? ☐ Very important ☐ Somewhat important ☐ Neutral ☐ Not very important ☐ Not important at all

30. Should interpreters follow the same emotional support guidelines as other healthcare professionals? ☐ Yes, exactly the same ☐ Yes, but less intensive ☐ Yes, but more intensive ☐ No, different approach ☐ No, no emotional support

31. Do you think interpreters should provide emotional support to patients? ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

32. Please explain your reasoning:

33. What benefits do you see from interpreter emotional support for LEP patients? (check all that apply) ☐ Improved patient comfort ☐ Better communication ☐ Increased patient trust ☐ Reduced patient anxiety ☐ Cultural understanding ☐ Better health outcomes ☐ No benefit ☐ Other (please specify): _____

34. What concerns do you have about interpreter emotional support? (check all that apply) ☐ Professional boundary violations ☐ Liability issues ☐ Inconsistent care ☐ Role confusion ☐ Time management ☐ No concerns ☐ Other (please specify): _____

35. How often do you include interpreters in care planning discussions? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

36. When interpreters provide cultural insights, how often do you incorporate their suggestions into care plans? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐ Not applicable (interpreters don't provide cultural insights)

37. What would improve collaboration between healthcare providers and interpreters?

38. Have you ever experienced situations where an interpreter's assistance beyond language interpreting created challenges? ☐ Yes ☐ No

39. If yes, please describe what happened:

Section D: Professional Development and Training

40. Have you received training on working effectively with medical interpreters? ☐ Yes ☐ No

41. If yes, what type of training have you received? (check all that apply) ☐ Orientation sessions ☐ In-service training ☐ Conference workshops ☐ Online modules ☐ Cultural competency training ☐ Other (please specify): _____

42. Would you like additional training on working with medical interpreters? ☐ Yes ☐ No ☐ Not sure

43. How could interpreter services be improved to better support your work with LEP patients?

Closing Question

44. Now that you have completed this survey, what else would you like to share with me about your experience with medical interpreters?

Thank you for your participation! Your responses will improve understanding of healthcare provider perspectives on interpreter roles.

If you have any questions about this study, please contact Marisa Rueda Will at mruedawill24@mail.wou.edu.

Spanish-Speaking LEP Patient Survey (English Version)

LEP Patient Survey – The Hidden Roles of Healthcare Interpreters

Introduction

This survey asks about your experiences with medical interpreters in healthcare settings. We want to learn how interpreters assist patients by doing tasks in addition to interpreting. Your answers will improve medical interpreter services. The survey takes about 20-30 minutes to complete. No identifying information such as name or email will be collected to keep all responses anonymous.

About Interpreter Job Guidelines: Interpreters have job guidelines about their role. Sometimes they may assist you in ways beyond interpreting. Your experience will assist us in understanding how interpreters can best support patients.

Definitions for this survey:

- **Culture**: Your country of origin, traditions, and customs.
- **Emotional support**: Providing comfort, reassurance, or understanding in addition to interpreting medical information.
- **Professional Interpreter**: A trained person who helps you communicate with your healthcare provider by accurately sharing what each person says.
- **Tasks beyond interpreting**: Any actions taken by interpreters during an encounter that go beyond the accurate and impartial transfer of spoken or signed messages between parties, including assuming roles, responsibilities, or interactions not inherent to the interpreting function, such as providing opinions or advice, engaging in decision-making

or advocacy, performing administrative or clinical tasks, or responding directly to the emotional expressions or needs of patients, family members, or providers.

- **Other**: Any additional concepts, activities, or situations not covered by the above definitions

SECTION A: BACKGROUND INFORMATION

1. What is your age range? ☐ 18–29 ☐ 30–39 ☐ 40–49 ☐ 50–59 ☐ 60 or older ☐ Prefer not to answer

2. What is your gender identity? ☐ Female ☐ Male ☐ Non-binary ☐ Other: _____ ☐ Prefer not to answer

3. What is your preferred language for healthcare conversations?

4. How long have you been living in the United States? ☐ Less than 1 year ☐ 1–5 years ☐ 6–10 years ☐ 11–20 years ☐ More than 20 years ☐ Born in U.S.

5. What is your highest education level? ☐ Elementary school ☐ Some high school ☐ High school diploma/GED ☐ Some college ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ PhD/Doctoral degree ☐ None ☐ Prefer not to answer

6. How often do you receive interpreter services in healthcare settings? ☐ This is my first time ☐ Occasionally (few times per year) ☐ Regularly (monthly) ☐ Frequently (weekly or more)

Section B: Interpreting Experience

7. What type of professional interpreting service do you typically receive? (check all that apply) ☐ Interpreter who comes in person ☐ Video call with interpreter ☐ Phone call with interpreter ☐ Hospital/clinic staff who speaks my language

8. Please indicate the percentage of the time you work with each modality: In-person: _____% | VRI: _____% | OPI: _____% | Bilingual Staff Members: _____% ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

9. Please indicate the percentage of the time you receive different types of interpreter services: Staff hospital interpreter: _____% | Freelance or agency interpreter: _____% | Remote interpreter (video or phone): _____% | Hospital staff member that speaks your language: _____% Not sure: _____% ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

10. How often do family members interpret for you during medical visits? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

11. Do you notice differences in how interpreters can assist you in different types of interpreter services (in-person, video, phone)? ☐ Yes, significant differences ☐ Yes, some differences ☐ No differences ☐ Haven't noticed ☐ I only use one type

12. What things are most important for interpreters to give you good care? (check all that apply) ☐ Being in the room with me ☐ Being able to see me ☐ Speaking my language very well ☐ Having experience ☐ Knowing how hospitals work ☐ Knowing medical words ☐ Clear sound/video quality ☐ Having enough time ☐ Being included in talks with my doctor ☐ Understanding my culture ☐ Having time to prepare ☐ Other : _____

Section C: Medical Specialties and Interpreter Qualifications

13. Do you know if your interpreter is certified or has received special training for medical interpreting? ☐ Yes, they are nationally certified ☐ Yes, they have a certificate ☐ Yes, they have special training ☐ No, they don't have either ☐ I don't know ☐ I'm not sure what this means ☐ I didn't think to ask

14. How often do you visit healthcare providers? ☐ Weekly or more ☐ Monthly ☐ Every few months ☐ Once or twice per year ☐ Rarely

15. Which healthcare settings do you usually visit? (check all that apply) ☐ Hospital ☐ Outpatient clinic ☐ Emergency Department ☐ Urgent care ☐ Other: _____

16. Which specialty areas do you typically visit? (check all that apply) ☐ Emergency Department ☐ Primary care ☐ Mental/Behavioral Health ☐ Internal Medicine ☐ Pediatrics ☐ Surgery ☐ Cardiology ☐ None ☐ Other: _____

Section D: Activities Beyond Interpreting

17. Do you speak any other languages besides your preferred language and English? ☐ Yes: _____ ☐ No

18. If yes, which other language do you speak?

19. Interpreters have job guidelines that say they should only interpret what is said and not add their personal opinions or leave anything out of what is said. However, when you or your doctor were having trouble with communication or understanding, when did your interpreter step in to assist? (check all that apply)

A) ☐ Right away when they noticed the problem

B) ☐ After the doctor/nurse tried a few times

C) ☐ Only when someone asked them to assist

D) ☐ When I seemed upset or confused

E) ☐ When it involved cultural differences

F) ☐ When it involved complex medical information that needed explaining

G) ☐ They always waited for permission first

H) ☐ The interpreter never stepped in to assist with communication difficulties between me and my provider.

I) ☐ Other: _____

20. Look back at your answers in Q13. Of those times you checked, rank your TOP 3 by writing the letters below:

Most common: _____ (write letter: A, B, C, etc.)

Second most common: _____

Third most common: _____

21. Besides interpreting your conversations, did your interpreter assist you directly with any of these things (without a doctor or nurse doing it)? (check all that apply) ☐ Setting up appointments ☐ Understanding medical procedures and next steps ☐ Getting around and finding resources ☐ Insurance questions ☐ Finding community resources and hospital directions ☐ Speaking up for my needs ☐ None of these ☐ Other: _____

22. If your interpreter assisted with any of these, how useful was it? ☐ Not useful ☐ A little useful ☐ Somewhat useful ☐ Very useful ☐ Extremely useful ☐ The interpreter never assisted me with any of these tasks

23. Please explain your reasoning:

Section E: Emotional Support and Cultural Connection

24. Did your interpreter provide emotional support or comfort during your medical care? ☐ Yes, a lot ☐ Yes, some ☐ A little ☐ Not at all ☐ I'm not sure

25. If yes, how did they provide comfort or support? (check all that apply) ☐ Spoke to me in a caring way in my own language ☐ Stayed with me during scary or painful procedures ☐ Assisted me in feeling less alone in the hospital/clinic ☐ Explained things in a way that made cultural sense to me ☐ Made me feel understood because we shared the same background ☐ Assisted me in feeling calmer when I was worried ☐ Other ways: _____ ☐ Not applicable

26. How often is the interpreter the only member of your healthcare team who speaks your preferred language? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

27. How often is the interpreter the only member of your healthcare team who understands your culture? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

28. How did having an interpreter who spoke your language make you feel? ☐ Much more comfortable ☐ Somewhat more comfortable ☐ No difference ☐ Somewhat less comfortable ☐ Much less comfortable ☐ Other: _____

29. If your interpreter understood your culture, how did this make you feel? ☐ Much more comfortable ☐ Somewhat more comfortable ☐ No difference ☐ Somewhat less comfortable ☐ Much less comfortable ☐ My interpreter didn't understand my culture ☐ Other: _____

Section F: Familiarity Working with Interpreters

30. Before meeting with an interpreter, what did you expect they would do for you? (check all that apply) ☐ Only interpret ☐ Assist me in understanding cultural differences ☐ Provide comfort during difficult moments ☐ Assist me in feeling less alone ☐ Speak up for my needs ☐ I wasn't sure what to expect ☐ Other: _____

31. Did your interpreter explain their role or job to you? ☐ Yes, clearly explained ☐ Yes, briefly mentioned ☐ No explanation given ☐ I don't remember

32. Are you familiar with job guidelines that interpreters must follow? ☐ Yes, very familiar ☐ Yes, somewhat familiar ☐ No, not familiar ☐ I don't know what these are

Section G: Medical Interpreters and the Healthcare Team

33. How important is it for healthcare providers to provide emotional support during your medical care? ☐ Very important ☐ Somewhat important ☐ Neutral ☐ Not very important ☐ Not important at all

34. Do you consider interpreters to be part of your healthcare team? ☐ Yes, definitely ☐ Yes, somewhat ☐ Not sure ☐ No, not really ☐ No, definitely not

35. Should interpreters provide the same kind of emotional support as other healthcare providers? ☐ Yes, the same ☐ Yes, but less ☐ Yes, but more ☐ No, different approach ☐ No, no emotional support

36. Do you think interpreters should provide emotional support and comfort to patients like you? ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

37. Please explain your reasoning:

38. Were there any times when your interpreter said they couldn't assist you with something because of their job rules? ☐ Yes ☐ No ☐ I'm not sure ☐ I don't remember

39. If yes, please describe what happened:

Section H: Experiences and Satisfaction

40. Did your interpreter do what you expected, or something different? ☐ Exactly what I expected ☐ More beneficial than expected ☐ Less beneficial than expected ☐ Different from what I expected ☐ I wasn't sure what to expect

41. Please explain how your interpreter's assistance was different from what you expected:

42. Overall, how satisfied were you with your interpreter's assistance? ☐ Very unsatisfied ☐ Unsatisfied ☐ Neutral ☐ Satisfied ☐ Very satisfied

43. Would you recommend interpreter services to other patients who speak your language? ☐ Yes, definitely ☐ Yes, probably ☐ Not sure ☐ Probably not ☐ Definitely not

44. What would improve interpreter services for patients like you?

Closing Question

45. Now that you have completed this survey, what else would you like to share with me about your experience with medical interpreters?

Thank you for your participation! Your responses will improve interpreter services.

If you have any questions about this study, please contact Marisa Rueda Will at mruedawill24@mail.wou.edu.

Spanish-Speaking LEP Patient Survey (Spanish Version Used for Data Collection)

El papel oculto de los intérpretes médicos: Cuestionario para pacientes con dominio limitado del inglés

Introducción

Esta encuesta hace preguntas sobre sus experiencias con intérpretes médicos en entornos de atención médica. Queremos aprender cómo los intérpretes ayudan a los pacientes desempeñando tareas adicionales a la interpretación. Sus respuestas mejorarán los servicios de interpretación médica. La encuesta toma aproximadamente entre 20 y 30 minutos para completarse. No se recopilará ninguna información identificativa como nombre o correo electrónico para mantener todas las respuestas anónimas.

Sobre las pautas laborales de los intérpretes: Los intérpretes tienen pautas laborales con respecto a su rol. Algunas veces pueden ayudarle de maneras que van más allá de la interpretación. Su experiencia nos ayudará a comprender cómo los intérpretes pueden apoyar mejor a los pacientes.

Definiciones para esta encuesta:

- **Cultura**: su país de origen, tradiciones y costumbres.
- **Apoyo emocional**: brindar consuelo, tranquilidad o comprensión además de interpretar información médica.

- **Intérprete profesional**: una persona capacitada que le ayuda a comunicarse con su proveedor de atención médica transmitiendo con precisión lo que dice cada persona.
- **Tareas más allá de la interpretación**: cualquier acción realizada por los intérpretes durante un encuentro que va más allá de la transmisión precisa e imparcial de mensajes hablados o por señas entre las partes, incluido asumir roles, responsabilidades o interacciones que no son inherentes a la función de interpretación, tales como brindar opiniones o consejos participar en la toma de decisiones o abogacía, realizar tareas administrativas o clínicas o responder directamente a las expresiones emocionales o necesidades de los pacientes, familiares o proveedores.
- **Otro**: cualquier concepto, actividad o situación adicional no cubierto por las definiciones anteriores

Sección A: información de contexto

1. ¿A cuál grupo de edad pertenece? ☐ 18–29 ☐ 30–39 ☐ 40–49 ☐ 50–59 ☐ 60 o mayor ☐ Prefiere no contestar

2. ¿Cuál es su identidad de género? ☐ Femenino ☐ Masculino ☐ No binario ☐ Otro: _____ ☐ Prefiere no contestar

3. ¿Cuál es su idioma preferido para conversaciones de atención médica?

4. ¿Por cuánto tiempo ha vivido en los Estados Unidos? ☐ Menos de 1 año ☐ 1 a 5 años ☐ 6 a 10 años ☐ 11 a 20 años ☐ Más de 20 años ☐ Nació en los Estados Unidos

5. ¿Cuál es su nivel máximo de estudios? ☐ Escuela primaria ☐ Algo de estudios de secundaria ☐ Diploma de secundaria/GED ☐ Algo de estudios universitarios ☐ Título universitario técnico (de dos años) ☐ Título universitario ☐ Doctorado ☐ Ninguno ☐ Prefiere no contestar ☐ Otro:
6. ¿Con qué frecuencia recibe servicios de interpretación en entornos de atención médica? ☐ Esta es mi primera vez ☐ Ocasionalmente (pocas veces al año)
☐ Regularmente (mensualmente) ☐ Frecuentemente (semanalmente o más)

Sección B: experiencia con la interpretación

7. ¿Qué tipo de servicio de interpretación profesional recibe típicamente? (marque todas las que apliquen) ☐ Intérprete en persona ☐ Videollamada con intérprete
☐ Llamada telefónica con intérprete ☐ Personal del hospital/clínica que habla mi idioma

8. Por favor, indique qué porcentaje del tiempo recibe los servicios de interpretación en cada modalidad. ☐ Intérprete en persona _____% ☐ Videollamada con intérprete _____% ☐ Llamada telefónica con intérprete _____% ☐ Personal del hospital/clínica que habla mi idioma_____% ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

9. Por favor, indique qué porcentaje del tiempo recibe los diferentes tipos de servicios de interpretación. ☐ Intérprete de planta del hospital _____% ☐ Intérprete contratista de una agencia local _____% ☐ Intérprete a distancia (por video o por teléfono) de una compañía externa _____% ☐ Personal del hospital/clínica que habla mi idioma _____% ☐ No estoy seguro _____% ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

10. ¿Con qué frecuencia los miembros de su familia interpretan para usted durante las visitas médicas? ☐ Nunca ☐ Raramente ☐ Algunas veces ☐ A menudo ☐ Siempre

11. ¿Nota diferencias en cómo los intérpretes pueden ayudarle en diferentes tipos de servicios de interpretación (en persona, por video, por teléfono)?
☐ Sí, diferencias significativas ☐ Sí, algunas diferencias ☐ No hay diferencias
☐ No lo he notado ☐ Solo he recibido un tipo de servicio de interpretación

12. ¿Qué es lo más importante para que los intérpretes le brinden una buena atención? (marque todas las que aplican) ☐ Que estén en la habitación conmigo ☐ Poder verme
☐ Que hable muy bien mi idioma ☐ Tener experiencia laboral como intérprete ☐ Conocer cómo funcionan los hospitales ☐ Conocer los términos médicos ☐ Calidad clara de sonido/video
☐ Tener suficiente tiempo ☐ Ser incluido en las conversaciones con mi doctor
☐ Comprender mi cultura ☐ Tener tiempo para prepararse ☐ Otro: _____

Sección C: especialidades médicas y calificaciones de los intérpretes

13. ¿Conoce si su intérprete tiene alguna capacitación especial para la interpretación médica? ☐ Sí, tiene una certificación nacional ☐ Sí, tiene un certificado ☐ Sí, tiene capacitación especial ☐ No, no tiene ninguna ☐ No lo sé ☐ No sé con certeza qué significa esto ☐ No pensé en preguntar ☐ Otro
14. ¿Con qué frecuencia visita proveedores de atención médica? ☐ Semanalmente o más
☐ Mensualmente ☐ Cada pocos meses ☐ Una o dos veces al año ☐ Raramente

15. ¿Qué entornos de atención médica visita usualmente? (marque todas las que aplican) ☐ Hospital ☐ Clínica ambulatoria ☐ Departamento de emergencias ☐ Atención urgente ☐ Otro: _____

16. ¿Cuáles especialidades médicas visita típicamente? (marque todas las que aplican)
☐ Departamento de emergencias ☐ Atención primaria ☐ Salud mental/conductual
☐ Medicina interna ☐ Pediatría ☐ Cirugía ☐ Cardiología ☐ Ninguna ☐ Otra: _____

Sección D: actividades más allá de la interpretación

17. ¿Habla algún otro idioma además de su idioma preferido y del inglés? ☐ Sí ☐ No

18. En caso afirmativo, ¿cuál es el otro idioma que habla?

19. Los intérpretes tienen pautas laborales que establecen que solo deben interpretar lo que se dice y no agregar sus opiniones ni omitir nada de lo dicho. Sin embargo, cuando usted o su doctor tuvieron problemas de comunicación o de entendimiento, ¿en qué momento intervino su intérprete para ayudar? (marque todas las que aplican)

A) ☐ Apenas se dio cuenta del problema.

B) ☐ Después de que el doctor o la enfermera lo intentó varias veces.

C) ☐ Solo cuando alguien le pidió ayuda.

D) ☐ Cuando me notó molesto o confundido.

E) ☐ Cuando se trataba de diferencias culturales.

F) ☐ Cuando se trataba de información médica compleja que requería una explicación

G) ☐ Siempre pidió permiso primero.

H) ☐ El intérprete nunca intervino para ayudar con dificultades de comunicación entre mi proveedor y yo.

I) ☐ Otro: _____

20. Revise sus respuestas en la pregunta anterior. De esas ocasiones que marcó, clasifique sus 3 ocasiones principales escribiendo las letras a continuación:

Más común: _____ (escriba la letra: A, B, C, etc.)

Segunda más común: _____

Tercera más común: _____

21. Además de interpretar sus conversaciones, ¿su intérprete le ayudó directamente con alguna de las siguientes cosas (sin que lo hiciera otro trabajador sanitario)? (marque todas las que aplican) ☐ Programar citas ☐ Comprender procedimientos médicos y los pasos que seguían ☐ Cómo desplazarse y encontrar recursos ☐ Preguntas del seguro
☐ Encontrar recursos comunitarios y direcciones para llegar al hospital
☐ Expresar mis necesidades ☐ Ninguna de estas ☐ Otra: _____

22. Si su intérprete le ayudó con alguna de estas, ¿cuán útil fue? ☐ No fue útil
☐ Un poco útil ☐ Algo útil ☐ Muy útil ☐ Extremadamente útil ☐ El intérprete nunca me ayudó con ninguna de estas tareas

23. Por favor, explique su razonamiento:

Sección E: apoyo emocional y conexión cultural

24. ¿Su intérprete le brindó apoyo emocional o consuelo durante su atención médica?

☐ Sí, bastante ☐ Sí, algo ☐ Un poco ☐ Para nada ☐ No estoy seguro

25. Si la respuesta es afirmativa, ¿cómo le brindó consuelo o apoyo? (marque todas las que aplican) ☐ Me habló de manera afectuosa en mi propio idioma ☐ Se quedó conmigo durante procedimientos intimidantes o dolorosos ☐ Me ayudó a sentirme menos solo en el hospital/la clínica ☐ Me explicó las cosas de una manera que tuviera sentido cultural para mi ☐ Me hizo sentir comprendido porque compartíamos el mismo origen ☐ Me ayudó a sentirme más calmado cuando estaba preocupado ☐ Otras maneras: _____ ☐ No aplica

26. ¿Con cuánta frecuencia el intérprete es el único miembro de su equipo de atención médica que habla su idioma preferido? ☐ Siempre ☐ A menudo ☐ Algunas veces
☐ Raramente ☐ Nunca

27. ¿Con cuánta frecuencia el intérprete es el único miembro de su equipo de atención médica que entiende su cultura? ☐ Siempre ☐ A menudo ☐ Algunas veces ☐ Raramente ☐ Nunca

28. ¿Cómo le hizo sentir tener a un intérprete que habla su idioma? ☐ Mucho más cómodo ☐ Un poco más cómodo ☐ No hubo diferencia ☐ Un poco menos cómodo ☐ Mucho menos cómodo ☐ Otro: _____

29. Si su intérprete comprendió su cultura, ¿cómo le hizo sentir esto? ☐ Mucho más cómodo ☐ Un poco más cómodo ☐ No hubo diferencia ☐ Un poco menos cómodo ☐ Mucho menos cómodo ☐ Mi intérprete no comprendió mi cultura ☐ Otro: _____

Sección F: familiaridad trabajando con intérpretes

30. Antes de reunirse con un intérprete, ¿qué esperaba que hicieran por usted? (marque todas las que apliquen) ☐ Solo interpretar ☐ Ayudarme a comprender las diferencias culturales ☐ Brindar consuelo durante momentos difíciles ☐ Ayudarme a sentirme menos solo ☐ Hacer valer mis necesidades ☐ No sabía qué esperar ☐ Otro: _____

31. ¿Su intérprete le explicó cuál es su rol o su trabajo? ☐ Sí, lo explicó claramente ☐ Sí, lo mencionó brevemente ☐ No brindó ninguna explicación ☐ No lo recuerdo

32. ¿Conoce las pautas laborales que los intérpretes deben seguir? ☐ Sí, las conozco ☐ Sí, las conozco un poco ☐ No, no las conozco ☐ No sé qué son

Sección G: intérpretes médicos y el equipo de atención médica

33. ¿Qué tan importante es para los proveedores de atención médica brindar apoyo emocional durante su atención médica? ☐ Muy importante ☐ Algo importante ☐ Neutral ☐ No muy importante ☐ Para nada importante

34. ¿Considera que los intérpretes son parte de su equipo de atención médica?
☐ Sí, definitivamente ☐ Sí, un poco ☐ No estoy seguro ☐ No, no realmente ☐ No, definitivamente no

35. ¿Los intérpretes deberían brindar el mismo tipo de apoyo emocional que los demás proveedores de atención médica? ☐ Sí, el mismo ☐ Sí, pero menos ☐ Sí, pero más ☐ No, un enfoque diferente ☐ No, nada de apoyo emocional
36. ¿Piensa que los intérpretes deben brindar apoyo emocional y consuelo a los pacientes como usted? ☐ Totalmente de acuerdo ☐ De acuerdo ☐ Neutral
☐ En desacuerdo ☐ Totalmente en desacuerdo

37. Por favor, explique su razonamiento:

38. ¿Hubo algún momento en que su intérprete indicó que no podía ayudarle con algo debido a las normas de su trabajo? ☐ Sí ☐ No ☐ No estoy seguro ☐ No recuerdo

39. Si la respuesta es afirmativa, describa qué ocurrió:

Sección H: experiencias y satisfacción

40. ¿Su intérprete hizo lo que usted esperaba, o algo diferente? ☐ Exactamente lo que esperé ☐ Más beneficioso de lo que esperaba ☐ Menos beneficioso de lo que esperaba ☐ Diferente a lo que esperaba ☐ No estaba seguro de qué esperar

41. Por favor, explique su razonamiento:

42. En general, ¿qué tan satisfecho estuvo con la ayuda de su intérprete? ☐ Muy insatisfecho ☐ Insatisfecho ☐ Neutral ☐ Satisfecho ☐ Muy satisfecho

43. ¿Recomendaría los servicios de interpretación a otros pacientes que hablan su idioma? ☐ Sí, definitivamente ☐ Sí, probablemente ☐ No estoy seguro ☐ Probablemente no
☐ Definitivamente no

44. ¿Qué mejoraría los servicios de interpretación para pacientes como usted?

¡Gracias por su participación! Sus respuestas mejorarán los servicios de interpretación.

Si tiene alguna pregunta sobre este estudio, contacte a Marisa Rueda Will en mruedawill24@mail.wou.edu.

Appendix B: Consent Forms

Medical Interpreter Consent

Research Study Title: The Hidden Roles of Medical Interpreters

You are invited to participate in a questionnaire about your experiences as a medical interpreter in healthcare settings. This research project is being conducted by Marisa Rueda Will, a graduate student at Western Oregon University, under the supervision of Dr. Elisa Maroney.

Eligibility

Participants must be 18 years or older and currently working as medical interpreters in healthcare settings.

Participation

Your participation in this questionnaire is voluntary. You may choose not to take part in the research or exit the questionnaire at any time without penalty. There is no penalty for not participating. This questionnaire should take approximately 15-20 minutes to complete.

Purpose

The goal of this questionnaire is to better understand how medical interpreters navigate professional boundaries and role expectations in healthcare settings, particularly in situations involving patient advocacy, emotional support, and cultural mediation.

Timeline

The questionnaire will be open for four weeks after it is disseminated.

Benefits

You will receive no direct benefits from participating in this research study. However, your responses may help improve understanding of interpreter roles and contribute to better professional guidelines and training programs. This research may also help healthcare institutions better support interpreters and improve patient care. Participants will not receive compensation for their involvement in the research.

Risks

There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Some questions ask about professional and ethical challenges you may have experienced, which could cause minor discomfort. If you experience any undue distress from this experience, you are advised to seek appropriate support or counseling services. You may close your browser and withdraw from this study at any time without penalty.

Confidentiality

The information gathered from this questionnaire will be anonymous. Your answers will be collected via a secure web-based survey platform, where data will be stored in a password-protected electronic format. There will be no collection of identifying information such as your name, email address, or IP address. Therefore, your responses will remain anonymous. No one will be able to identify you or your answers.

Contact

You may contact Marisa Rueda Will at mruedawill24@mail.wou.edu should you have any questions or concerns about this questionnaire or the research project as a whole. You may also contact the research advisor, Dr. Elisa Maroney, via email at maronee@mail.wou.edu.

This study has been reviewed and approved by Western Oregon University Institutional Review Board (IRB). If you have any questions or concerns regarding this study, your rights as a subject/participant in this research, or if you feel you have been placed at risk and would like to talk to someone other than the researcher, you are encouraged to contact the Western Oregon University Institutional Review Board at irb@wou.edu or 503-838-9200.

Consent

By proceeding with this questionnaire, you acknowledge that:

- You have read and understood the information provided above
- You are 18 years of age or older
- You currently work as a medical interpreter
- You voluntarily consent to participate in this research study
- You understand you may withdraw from the study at any time without penalty

Thank you,

Marisa Rueda Will Western Oregon University, Masters of Interpreting Studies Program

Healthcare Provider Consent

Research Study Title: The Hidden Roles of Medical Interpreters

You are invited to participate in a questionnaire about your experiences working with medical interpreters in healthcare settings. This research project is being conducted by Marisa Rueda Will, a graduate student at Western Oregon University, under the supervision of Dr. Elisa Maroney.

Eligibility

Participants must be 18 years or older and currently working as healthcare providers (e.g., physicians, nurses, nurse practitioners, physician assistants, social workers, and administrative staff) who collaborate with medical interpreters and Limited English Proficient (LEP) patients.

Participation

Your participation in this questionnaire is voluntary. You may choose not to take part in the research or exit the questionnaire at any time without penalty. There is no penalty for not participating. This questionnaire should take approximately 15-20 minutes to complete.

Purpose

The goal of this questionnaire is to better understand healthcare providers' observations and perspectives on how medical interpreters contribute to patient care beyond language interpreting,

including their views on interpreter roles in patient advocacy, emotional support, and cultural mediation.

Timeline

The questionnaire will be open for four weeks after it is disseminated.

Benefits

You will receive no direct benefits from participating in this research study. However, your responses may help improve understanding of interpreter-provider collaboration and contribute to better training programs for both interpreters and healthcare providers. This research may also help healthcare institutions optimize interpreter services to improve patient care for LEP populations. Participants will not receive compensation for their involvement in the research.

Risks

There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Some questions ask about your professional experiences and observations, which should not cause any discomfort. If you experience any undue distress from this experience, you are advised to seek appropriate support or counseling services. You may close your browser and withdraw from this study at any time without penalty.

Confidentiality

The information gathered from this questionnaire will be anonymous. Your answers will be collected via a secure web-based survey platform, where data will be stored in a password-protected electronic format. There will be no collection of identifying information such as your name, email address, or IP address. Therefore, your responses will remain anonymous. No one will be able to identify you or your answers.

Contact

You may contact Marisa Rueda Will at mruedawill24@mail.wou.edu should you have any questions or concerns about this questionnaire or the research project as a whole. You may also contact the research advisor, Dr. Elisa Maroney, via email at maronee@mail.wou.edu.

This study has been reviewed and approved by Western Oregon University Institutional Review Board (IRB). If you have any questions or concerns regarding this study, your rights as a subject/participant in this research, or if you feel you have been placed at risk and would like to talk to someone other than the researcher, you are encouraged to contact the Western Oregon University Institutional Review Board at irb@wou.edu or 503-838-9200.

Consent

By proceeding with this questionnaire, you acknowledge that:

- You have read and understood the information provided above
- You are 18 years of age or older

- You currently work as a healthcare provider who collaborates with medical interpreters
- You voluntarily consent to participate in this research study
- You understand you may withdraw from the study at any time without penalty

Thank you,

Marisa Rueda Will Western Oregon University, Masters of Interpreting Studies Program

Spanish-Speaking LEP Consent (English Version)

Research Study Title: The Hidden Roles of Medical Interpreters

You are invited to participate in a questionnaire about your experiences with medical interpreters in healthcare settings. This research project is being conducted by Marisa Rueda Will, a graduate student at Western Oregon University, under the supervision of Dr. Elisa Maroney.

Eligibility

Participants must be Spanish-speaking adults (18 or older) with limited English proficiency who have received healthcare services while working with a professional medical interpreter.

Participation

Your participation in this questionnaire is voluntary. You may choose not to take part in the research or exit the questionnaire at any time without penalty. There is no penalty for not participating. This questionnaire should take approximately 20-30 minutes to complete.

Purpose

The goal of this questionnaire is to better understand patient experiences with medical interpreters, including how interpreters help patients beyond just interpreting spoken language. Your feedback will help improve interpreter services for patients who need language assistance.

Timeline

The questionnaire will be open for four weeks after it is distributed.

Benefits

You will receive no direct benefits from participating in this research study. However, your responses may help improve interpreter services and training programs, which could benefit future patients who need language assistance in healthcare settings. This research may also help healthcare institutions better serve patients who speak languages other than English. Participants will not receive compensation for their involvement in the research.

Risks

There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Some questions ask about your healthcare experiences, which should not

cause any discomfort. If you experience any undue distress from this experience, you are advised to seek appropriate support or counseling services. You may close your browser and withdraw from this study at any time without penalty.

Confidentiality

The information gathered from this questionnaire will be anonymous. Your answers will be collected via a secure web-based survey platform, where data will be stored in a password-protected electronic format. There will be no collection of identifying information such as your name, email address, or IP address. Therefore, your responses will remain anonymous. No one will be able to identify you or your answers.

Contact

You may contact Marisa Rueda Will at mruedawill24@mail.wou.edu should you have any questions or concerns about this questionnaire or the research project. You may also contact the research advisor, Dr. Elisa Maroney, via email at maronee@mail.wou.edu.

This study has been reviewed and approved by Western Oregon University Institutional Review Board (IRB). If you have any questions or concerns regarding this study, your rights as a subject/participant in this research, or if you feel you have been placed at risk and would like to talk to someone other than the researcher, you are encouraged to contact the Western Oregon University Institutional Review Board at irb@wou.edu or 503-838-9200.

Consent

By proceeding with this questionnaire, you acknowledge that:

- You have read and understood the information provided above
- You are 18 years of age or older
- You are a Spanish speaker with limited English proficiency
- You have received healthcare services while working with a professional medical interpreter
- You voluntarily consent to participate in this research study
- You understand you may withdraw from the study at any time without penalty

Thank you,

Marisa Rueda Will Western Oregon University, Masters of Interpreting Studies Program

Spanish-Speaking LEP Consent (Spanish Version Used for Data Collection)

Título del estudio de investigación: El papel oculto de los intérpretes médicos

Está invitado a participar en un cuestionario sobre sus experiencias con intérpretes médicos en entornos de atención médica. Este proyecto de investigación está siendo realizado por Marisa

Rueda Will, una estudiante de posgrado en la Western Oregon University, bajo la supervisión de la Dra. Elisa Maroney.

Elegibilidad

Los participantes deben ser adultos (18 años o mayores) que hablen español y tengan un dominio limitado del inglés que hayan recibido servicios de atención médica mientras trabajaban con un intérprete médico profesional.

Participación

Su participación en este cuestionario es voluntaria. Puede optar por no participar en la investigación o abandonar el cuestionario en cualquier momento sin penalización. No hay ninguna penalización por no participar. Este cuestionario debería tomar aproximadamente entre 20 y 30 minutos para completarse.

Propósito

El objetivo de este cuestionario es comprender mejor las experiencias de los pacientes con intérpretes médicos, incluido cómo los intérpretes ayudan a los pacientes más allá de simplemente interpretar el lenguaje hablado. Sus comentarios ayudarán a mejorar los servicios de interpretación para pacientes que necesitan asistencia lingüística.

Cronograma

El cuestionario estará disponible durante cuatro semanas después de su distribución.

Beneficios

Usted no recibirá beneficios directos por participar en este estudio de investigación. Sin embargo, sus respuestas pueden ayudar a mejorar los servicios de interpretación y los programas de capacitación, lo que puede beneficiar a futuros pacientes que necesiten asistencia lingüística en entornos de atención médica. Esta investigación también puede ayudar a que las instituciones de atención médica brinden un mejor servicio a los pacientes que hablen otros idiomas además del inglés. Los participantes no recibirán compensación por su participación en la investigación.

Riesgos

No se prevén riesgos por participar en este estudio aparte de los que se encuentran en la vida cotidiana. Algunas preguntas se refieren a sus experiencias de atención médica, lo cual no debería causar ninguna incomodidad. Si esta experiencia le causa alguna angustia indebida, le recomendamos que busque el apoyo o los servicios de asesoramiento adecuados.

Confidencialidad

La información recolectada en este cuestionario será anónima. Sus respuestas serán recolectadas a través de una plataforma de encuestas web segura, en donde los datos se almacenarán en un formato electrónico protegido por contraseña. No se recopilará información identificativa como su nombre, dirección de correo electrónico o dirección IP. Por lo tanto, sus respuestas serán anónimas. Nadie podrá identificarle a usted o a sus respuestas.

Contacto

Puede contactar a Marisa Rueda Will en mruedawill24@mail.wou.edu si tiene alguna pregunta o inquietud sobre este cuestionario o el proyecto de investigación. También puede contactar al asesor de la investigación, la Dra. Elisa Maroney, por correo electrónico a maronee@mail.wou.edu.

La Junta de Revisión Institucional (IRB, por sus siglas en inglés) de la Western Oregon University ha revisado y aprobado este estudio. Si tiene alguna pregunta o inquietud con respecto a este estudio, sus derechos como un sujeto/participante en esta investigación o si siente que ha sido puesto en riesgo y le gustaría hablar con alguien que no sea la investigadora, le recomendamos contactar a la Junta de Revisión Institucional de la Western Oregon University al irb@wou.edu o al 503-838-9200.

Consentimiento

Al continuar con este cuestionario, usted reconoce que:

- Ha leído y comprendido la información proporcionada anteriormente.
- Tiene 18 años o más.
- Habla español con un dominio limitado del inglés.
- Ha recibido servicios de atención médica mientras trabajaba con un intérprete médico profesional.
- Usted otorga su consentimiento voluntario para participar en este estudio de investigación.
- Usted comprende que puede abandonar el estudio en cualquier momento sin penalización.

Muchas gracias,

Marisa Rueda Will, Western Oregon University, Programa de Maestría en Estudios de Interpretación