Best Practices for Working with Interpreters in the Medical Setting

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Feb-March 2025

Abstract

Millions of people in the United States require use of interpreters to access healthcare services. Professional interpreters and untrained, ad hoc interpreters—who may be a family member of the patient, hospital staff, or stranger—are both used in the medical setting. Modalities include in person and remote, via videoconference or telephone, as well as emerging artificial intelligence and direct translation technologies. In-person professional interpreters are ideal for most situations. Not all medical students and residents receive formal education or training on best practices for working with interpreters. Practical tips for all stages of the encounter—preparation and chart review, patient interview, debriefing, and documentation—are included at the end of this paper.

Introduction

According to the most recent census data from 2020, 8.4% of people over the age of 5 years old in the United States speak English less than very well.[1] This means over 25 million people meet the criteria for Limited English Proficiency (LEP).[2] Health professionals and institutions who receive federal financial assistance are legally required to make a reasonable effort to provide access to interpreter (spoken language) and translator (written language) services to LEP patients at no additional cost.[2,3] Federal requirements only call for "qualified" interpreters, who have proven proficiency in English and a second language and can effectively, accurately, and confidentially interpret clinical information.[2] Some states require licensed or certified interpreters, who have completed formal training and examinations and maintain their credentials through continuing education. However, these certification programs do not exist for all languages.[4] National organizations for healthcare interpreters have agreed on a code of ethics that emphasizes beneficence, cultural sensitivity, and commitment to faithful interpretation.[2,5]

Professional interpreters are hired or contracted by healthcare organizations and compensated for their services.[6] Ad hoc interpreters can be relational (i.e. family members, friends, or acquaintances who accompany the patient), part of the healthcare system (i.e. bilingual physicians, other staff, or medical students for whom interpretation is not one of their official duties), or strangers (e.g. volunteers from the waiting room, local community, or online crowdsourcing) who are recruited to interpret in the absence of a professional interpreter or according to patient preference.[7,8,9] Interpreters can be in person or remote, joining the appointment via videoconference or telephone.[10]

Learning best practices for working with these various interpreter types and modalities is essential for providing effective care to LEP patients. Training for working with interpreters is not standardized in medical schools or residency programs, but medical students and residents have shown interest in honing these skills.[3]

Type of Interpreter – *Professional vs Ad Hoc*

Professional interpreters are generally preferred compared to ad hoc interpreters. A systematic review that primarily involved Spanish-speaking, LEP patients found that clinicians and patients self-reported higher satisfaction and superior communication with a professional interpreter compared to an ad hoc interpreter or no interpreter.[11] Self-reported satisfaction with care is associated with improved health outcomes.[12]

Ad hoc interpreters have not completed medical terminology classes or HIPAA training and are more prone to errors and breaches of patient confidentiality.[13] One study of audiotaped emergency department (ED) visits in urban Massachusetts found that ad hoc interpreters made almost two-fold more errors with potential clinical consequences (i.e. incorrect medical history or explanation of the diagnosis and treatment) than professional interpreters.[14] The most common types of errors for ad hoc interpreters were omission or false fluency versus addition, substitution, and editorialization for professional interpreters. Despite these established issues, ad hoc interpreters are frequently used, even when against hospital policy.[6] Surveyed healthcare providers from a regional health system in South Carolina cited shorter wait times for engaging an ad hoc interpreter, technical difficulties with remote interpreters, or a professional interpreter not being available at all as major reasons. A study at two medical centers in San Francisco found that ad hoc interpreters were used more often than professional interpreters by physicians and nurses on their inpatient surgical and medical wards.[15] Surveyed members of the American Academy of Pediatrics reported using bilingual family members and bilingual staff more often than professional interpreters.[16] Of note, professional interpreters were more likely to be used in states with third-party reimbursement for language services.

Professional interpreters and ad hoc relational interpreters operate within different contexts. A study analyzing the content of interpreter-mediated interviews at a primary care clinic in Montreal found that the relational interpreter, due to their connection to the patient outside of the medical setting, may have goals separate from both the patient and healthcare provider, while the professional interpreter is a more neutral party.[8] In one interview, a physician recommended trying prunes instead of starting a medication for constipation, but the patient disagreed. The patient's son told the physician that the patient agreed with the plan. The study found that while professional interpreters were more likely to interpret such instances of disagreement than relational interpreters, they rarely advocated for patients (e.g. repeating a female patient's preference to see a female gynecologist). The authors posited that this was a consequence of professional interpreters' efforts to act as impartial conduits in accordance with their ethical code.

Bilingual healthcare providers can become certified interpreters or may be audited to assess their proficiency and in these cases may be considered nearly equivalent to professional interpreters.[12] However, untrained, unevaluated bilingual providers as well as medical students commonly serve as interpreters. Bilingual providers have been shown to exaggerate their competency in their non-native language on self-reports.[3] A study from a medical school in New Zealand found that a significant portion of medical students who were asked by clinicians to interpret for patients felt pressured or unconfident.[7] Some students were asked to interpret explanations

of complex procedures or obtain informed consents. Moreover, use of strangers as ad hoc interpreters is not well-studied, but it is not an uncommon practice. A Canadian retrospective study of interpreter recruitment over intercom in 5 hospitals reported that 1265 requests were placed between January 2018 and December 2020 for 48 different languages.[17] Providers resorted to asking strangers when professional interpreters, colleagues, or family members were not available.

While the evidence points to professional interpreters as the best option in most situations, they are not without their own challenges. Just as relational interpreters can pose privacy concerns, a patient may know an in-person interpreter from the community and may not feel comfortable discussing, for example, sexual health with them present.[13,4] There is also wide variability in education and training for professional interpreters.[2] The Massachusetts ED study results referenced earlier suggested that professional interpreters with at least 100 hours of training made significantly fewer errors.[14]

Modality of Interpretation – *In-person vs Video vs Phone*

Healthcare providers tend to prefer in-person interpretation to remote interpretation. In a study of post-partum, Spanish-speaking, LEP women in Charleston, providers and interpreters ranked in-person interpretation significantly higher on a Likert scale than remote methods.[10] On interview, providers mentioned difficulty positioning everyone in the room for visibility during video interpretation and technical problems with the video cutting out due to inadequate bandwidth. They reported not preferring phone interpretation due to poor audio quality, long set-up time, and not being able to see nonverbal cues. There was no significant difference in the patients' Likert scale ratings, but on interview, they preferred in-person interpreters due to better comprehension and being able to see the interpreter. There was a statistically significant longer wait time for videoconference versus in person; however, the mean difference of 2.5 minutes would not likely be clinically significant. In-person interviews took significantly longer than phone interviews, with a mean difference of 7.4 minutes. In the study of a regional health system in South Carolina referenced earlier, surveyed healthcare providers preferred in-person, then phone, and then video interpretation.[6] Conversely, this study found shorter wait times for engaging phone and video interpreters compared to in-person. However, technical difficulties with remote interpretation were noted to sometimes extend total encounter lengths.

Artificial intelligence (AI) and direct translation software are emerging interpretation modalities. ChatGPT and other large language models are many steps away from becoming advanced enough for use in medical interpretation and translation.[9] These models are trained primarily on English datasets and thus do not perform as well in other languages, with the biggest problem being accuracy. For best results, AI models should be trained with patient data, but this poses privacy risks. If an acceptable AI model were created, it would have to be thoroughly tested for safety in the clinical setting, and then clinicians would have to be trained on how to use it properly. AI medical interpretation does have some promise as a cheaper option for under-resourced areas, but not in the near future. Direct translation software (e.g. Google Translate) is also error-ridden.[18] The applications are easy to use but may produce unintelligible results. There are several healthcare-specific applications that have potential to be helpful when used in a

limited capacity. CALD has pre-set translated phrases and diagrams that could be used in emergencies or brief, simple encounters. X-prompt has 800 common medical phrases searchable in 23 languages.

Conclusion

Professional interpreters should always be offered to patients when available. Ad hoc interpreters should only be used if a professional interpreter is not available or if the patient declines. In-person interpretation is generally preferred to remote interpretation modalities. Patients may decline in-person professional interpreters and prefer phone interpretation when discussing sensitive matters. The most appropriate interpreter type and modality should be chosen via shared decision-making between the patient and provider.

Practical Tips for Working with Interpreters

Pre-Encounter

- Ensure that all LEP patients are aware that language services are available. Inform them of their right to an interpreter in writing in their preferred language.[13]
- Offer professional interpretation services to patients. If a patient declines professional interpretation, ask them why.[3]
- Arrange for an interpreter who speaks the same dialect as the patient and who may have knowledge of their culture.[3,4]
- If the patient speaks an uncommon language that is not included in your institution's interpretation services, contact refugee resettlement agencies in your area.[3]
- If the patient and provided interpreter interact outside of the healthcare setting, ensure that the patient is comfortable with the interpreter and offer alternatives if not.[5]
- If you plan or anticipate discussing sensitive topics with the patient during the encounter, ask the patient if they would prefer an in-person interpreter or remote interpreter.[4]
- If the patient requests an interpreter of a particular gender, honor their request. This may require using a remote interpreter even when an in-person interpreter is available.[3]
- Discuss relevant patient details and appointment goals with the interpreter prior to the patient encounter.[3,13]
- Ensure the interpreter knows they are welcome to ask you clarifying questions, request that you speak more slowly, and take notes during the encounter.[3,5]
- Ask the interpreter for advice on how to interact with the patient in a culturally appropriate manner. For example, learn how to greet the patient in their own language and ask if shaking hands with the opposite gender is permissible.[3,4]

- Arrange for the encounter to take place in a room that is sufficiently large to accommodate the in-person interpreter or equipment needed for interpretation.[5]
- Ensure that the room is well-lit, particularly when working with deaf or hard-of-hearing patients.[4]
- Provide a seat for everyone expected to be present during the encounter when space permits.[3]
- Schedule extra time for encounters with LEP patients if possible.[3,13]
- If multiple LEP patients require an interpreter for the same language, try to schedule them for consecutive appointments.

During the Encounter

- Have the interpreter sit beside or behind the patient needing interpretation.[13]
- Sit on the same level as the patient and face them.[3]
- Invite the interpreter to and allow time for them to introduce themselves and their role to the patient.[19]
- Ensure that you and the interpreter know the name and relationship to the patient of all individuals present for the encounter. Ask if anyone present has any English proficiency. Check that the patient is comfortable having everyone present for the duration of the appointment.[4]
- Address the patient directly using first-person language.[13]
- Do not speak too loudly.[4]
- Speak in short sentences,[13] and pause every 2-3 sentences (~20 words) to allow for interpretation.[3,4]
- Do not stack questions. Ask a single question and then allow for interpretation.[3,4,13]
- Pause to collect your thoughts before speaking so that statements and questions are clear and concise.[3]
- Do not use medical jargon or acronyms. Do not expect the interpreter to simplify technical language.[4,13]
- Avoid using idioms, analogies, and humor.[4,13]
- Prepare the patient before discussing delicate topics. For example, let the patient know that you ask these questions to everyone.[3]
- If the interpreter informs you that the question or statement you are asking may be perceived as offensive in the patient's culture, ask them to help you reframe it.[3]
- If a patient uses a particular term to describe a symptom or condition (analogous to an English-speaking patient referring to diabetes as "sugars"), verify that you correctly

understand the term, and then you may use this term for the rest of the encounter.[4]

- Observe the patient for nonverbal cues that may indicate trouble understanding the interpreted information.[4]

- If you do not understand what the patient is saying, do not rely on the interpreter alone to clarify. Ask the patient directly.[3]

- If you hear the interpreter use an English term when speaking with the patient, verify that the equivalent word or definition of the term was explained in the patient's language.[3]

- Periodically summarize what the patient has told you to confirm understanding.[13]

- Do not make comments in English that you would not want the patient to hear, as many LEP patients have some understanding of English.[13]

- In general, do not interrupt the patient while they are answering or the interpreter before they have finished relaying the patient's statement.[3,4,5]

- If the patient and interpreter have a lengthy back-and-forth exchange, ask the interpreter to explain what was discussed. In this case, you may need to interrupt to maintain efficiency.[4]

- Keep your own side conversations with others in the room to a minimum.[3,13] For example, if you are teaching a medical student, ask the interpreter to explain the purpose of the conversation and why it is not being interpreted to the patient.

- Ask the patient to teach-back key points and instructions. If the patient's response indicates incomplete understanding, repeat or explain the information in a different way. Then employ the teach-back method again until full understanding is reached.[13]

- Use visual aids to help with understanding.[4] For example, show and print the patient a picture of an over-the-counter product you are recommending.

- When you exit the room, communicate to the patient and interpreter if you plan to return and how long you will be gone.[3]

- Make sure to ask the patient if they have any questions or concerns before closing the encounter.[3]

Post-Encounter

- Provide the patient with an electronic and/or paper copy of key points and instructions.[4] You can ask in-person interpreters for help translating these written materials.[5] If the LEP patient is not literate, ask if one of their family members or friends can help them read the materials.[3]

- Debrief with the interpreter after the encounter closes. Provide feedback for the interpreter, and ask the interpreter for feedback.[3,4,13]

- If possible, ask the patient about their experience with the interpreter and whether they would be comfortable having the same interpreter in the future. If there are any significant issues, notify the RN coordinator to communicate with Language Services or notify Language Services directly.[3]

- Record the interpreter's name, identification number, and organization (e.g. Globo) in the patient's chart.[13]

Specific Situations

Ad Hoc/Untrained Interpreters

- Communicate the expectation that the ad hoc interpreter will perform sentence-by-sentence interpretation in the first person.[3,13]

- If an ad hoc interpreter was used due to patient preference, ask the patient if a professional interpreter may still be present (or on phone) in the room in case they are needed.[4]

- Document if the patient declined a professional interpreter,[13] and record the interpreter's name and relationship to the patient in the chart.[13]

- If an ad hoc interpreter was used due to an emergency situation, schedule a follow-up appointment with a professional interpreter.[3]

Telephonic and Video Interpretation

- Before beginning the encounter, confirm that the speaker and microphone are working properly.[3]

- Describe who is present in the room and all of their roles to the remote interpreter.[3]

- Turn off the video screen or face the camera away from the patient during sensitive parts of the physical exam.[5]

- If phone interpretation does not seem to be going smoothly, request a different phone interpreter.[4]

Pediatric Patients

- Do not use minors as interpreters, except in emergencies.[3,2]

- Let remote interpreters know the patient's age so that they use appropriate vocabulary.[3]

- If the minor patient has English proficiency but the caregiver accompanying them has LEP, make sure the interpreter interprets everything the child says in English for the caregiver as well as what you say during the appointment.[3]
- When interviewing adolescent patients alone, obtain the patient's permission to have the interpreter in the room for sensitive portions of the interview. Remind them that the discussion is confidential unless the patient or others are at risk of harm.

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Appendix: Practical Tips for Working with Interpreters

Pre-Encounter

Ensure that all limited English proficiency (LEP) patients are aware that language services are available. Inform them of their right to an interpreter in writing in their preferred language.
Offer professional interpretation services to patients. If a patient declines professional interpretation, ask them why.
Arrange for an interpreter who speaks the same dialect as the patient and who may have knowledge of their culture.
If the patient speaks an uncommon language that is not included in your institution's interpretation services, contact refugee resettlement agencies in your area.
If the patient and provided interpreter interact outside of the healthcare setting, ensure that the patient is comfortable with the interpreter and offer alternatives if not.
If you plan or anticipate discussing sensitive topics with the patient during the encounter, ask the patient if they would prefer an in-person interpreter or remote interpreter.
If the patient requests an interpreter of a particular gender, honor their request. This may require using a remote interpreter even when an in-person interpreter is available.
Discuss relevant patient details and appointment goals with the interpreter prior to the patient encounter.
Ensure the interpreter knows they are welcome to ask you clarifying questions, request that you speak more slowly, and take notes during the encounter.
Ask the interpreter for advice on how to interact with the patient in a culturally appropriate manner. For example, learn how to greet the patient in their own language and ask if shaking hands with the opposite gender is permissible.
Arrange for the encounter to take place in a room that is sufficiently large to accommodate the in-person interpreter or equipment needed for interpretation.
Ensure that the room is well-lit, particularly when working with deaf or hard-of-hearing patients.
Provide a seat for everyone expected to be present during the encounter when space permits.
Schedule extra time for encounters with LEP patients if possible.
If multiple LEP patients require an interpreter for the same language, try to schedule them for consecutive appointments.

During the Encounter

Have the interpreter sit beside or behind the patient needing interpretation.
Sit on the same level as the patient and face them.
Invite the interpreter to and allow time for them to introduce themselves and their role to the patient.
Ensure that you and the interpreter know the name and relationship to the patient of all individuals present for the encounter. Ask if anyone present has any English proficiency.
Check that the patient is comfortable having everyone present for the duration of the appointment.
Address the patient directly using first-person language.
Do not speak too loudly.
Speak in short sentences, and pause every 2-3 sentences (~20 words) to allow for interpretation.
Do not stack questions. Ask a single question and then allow for interpretation.
Pause to collect your thoughts before speaking so that statements and questions are clear and concise.
Do not use medical jargon or acronyms. Do not expect the interpreter to simplify technical language.
Avoid using idioms, analogies, and humor.
Prepare the patient before discussing delicate topics. For example, let the patient know that you ask these questions to everyone.
If the interpreter informs you that the question or statement you are asking may be perceived as offensive in the patient's culture, ask them to help you reframe it.
If a patient uses a particular term to describe a symptom or condition (analogous to an English-speaking patient referring to diabetes as "sugars"), verify that you correctly understand the term, and then you may use this term for the rest of the encounter.
Observe the patient for nonverbal cues that may indicate trouble understanding the interpreted information.
If you do not understand what the patient is saying, do not rely on the interpreter alone to clarify. Ask the patient directly.
If you hear the interpreter use an English term when speaking with the patient, verify that the equivalent word or definition of the term was explained in the patient's language.
Periodically summarize what the patient has told you to confirm understanding.
Do not make comments in English that you would not want the patient to hear, as many LEP patients have some understanding of English.

In general, do not interrupt the patient while they are answering or the interpreter before they have finished relaying the patient's statement.
If the patient and interpreter have a lengthy back-and-forth exchange, ask the interpreter to explain what was discussed. In this case, you may need to interrupt to maintain efficiency.
Keep your own side conversations with others in the room to a minimum. For example, if you are teaching a medical student, ask the interpreter to explain the purpose of the conversation and why it is not being interpreted to the patient.
Ask the patient to teach-back key points and instructions. If the patient's response indicates incomplete understanding, repeat or explain the information in a different way. Then employ the teach-back method again until full understanding is reached.
Use visual aids to help with understanding. For example, show and print the patient a picture of an over-the-counter product you are recommending.
When you exit the room, communicate to the patient and interpreter if you plan to return and how long you will be gone.
Make sure to ask the patient if they have any questions or concerns before closing the encounter.

Post-Encounter

Provide the patient with an electronic and/or paper copy of key points and instructions. You can ask in-person interpreters for help translating these written materials. If the LEP patient is not literate, ask if one of their family members or friends can help them read the materials.
Debrief with the interpreter after the encounter closes. Provide feedback for the interpreter, and ask the interpreter for feedback.
If possible, ask the patient about their experience with the interpreter and whether they would be comfortable having the same interpreter in the future. If there are any significant issues, notify the RN coordinator to communicate with Language Services or notify Language Services directly.
Record the interpreter's name, identification number, and organization (e.g. Globo) in the patient's chart.

Specific Situations

Ad Hoc/Untrained Interpreters
Communicate the expectation that the ad hoc interpreter will perform sentence-by-sentence interpretation in the first person.
Document if the patient declined a professional interpreter, and record the interpreter's name and relationship to the patient in the chart.
If an ad hoc interpreter was used due to patient preference, ask the patient if a professional interpreter may still be present (or on phone) in the room in case they are needed
If an ad hoc interpreter was used due to an emergency situation, schedule a follow-up appointment with a professional interpreter.
Telephonic and Video Interpretation
Before beginning the encounter, confirm that the speaker and microphone are working properly.
Describe who is present in the room and all of their roles to the remote interpreter.
Turn off the video screen or face the camera away from the patient during sensitive parts of the physical exam.
If phone interpretation does not seem to be going smoothly, request a different phone interpreter.
Pediatric Patients
Do not use minors as interpreters, except in emergencies.
Let remote interpreters know the patient's age so that they use appropriate vocabulary.
If the minor patient has English proficiency but the caregiver accompanying them has LEP, make sure the interpreter interprets everything the child says in English for the caregiver as well as what you say during the appointment.
When interviewing adolescent patients alone, obtain the patient's permission to have the interpreter in the room for sensitive portions of the interview. Remind them that the discussion is confidential unless the patient or others are at risk of harm.