Institutional and Systemic Factors Influencing the Accessibility and Effectiveness of Spanish-English Medical Interpretation Services in U.S. Hospitals

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This study examines how institutional and systemic factors—such as staffing shortages, modality preferences, and reimbursement policies—impact the accessibility and quality of Spanish-English medical interpretation services in U.S. hospitals.

Abstract

Language access to health care is legally mandated and essential for equitable, high-quality, safe care. With more than 25 million people in the U.S. considered Limited English Proficient (LEP)—two-thirds of whom are Spanish speakers—interpretation services are crucial (Haldar, Pillai, & Artiga, 2023; MACPAC, 2024). Yet hospitals often prioritize less expensive virtual options over in-person services (Jacobs, Shepard, Suaya, & Stone, 2004). This research examines how system-level decisions influence Spanish-English interpretation in hospitals. Based on surveys of 20 interpreters, five providers, and interviews with four Georgia hospital systems (referred to as Health Systems 1–4), it reports staffing shortages, a lack of cultural competency training, and workflow integration problems. Interpreters are frequently excluded from urgent care due to budget and scheduling barriers. Overreliance on virtual platforms negatively affects communication, particularly in high-stakes situations. Without stronger enforcement, investment, and policy change, Spanish-speaking patients will continue to face care gaps. Hospitals must prioritize interpretation at every step of care, not treat it as a checkbox.

Introduction

Language is the foundation of medical care. Every diagnosis, question, and treatment decision hinges on clear communication between provider and patient. In the U.S., over 25 million people are considered Limited English Proficient (LEP), with the majority speaking Spanish (Haldar et al., 2023; MACPAC, 2024). In Georgia, more than 382,000 Spanish-speaking LEP individuals account for roughly 4,000 healthcare visits daily (Migration Policy Institute [MPI], 2024; Vanguard Medical Group, 2024). Patients are entitled to interpretation under Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act, yet services are inconsistent, poorly integrated, or substandard (American Medical Association [AMA], 2017; U.S. Department of Labor [DOL], n.d.).

Hospitals frequently treat interpretation as an afterthought, favoring cheaper virtual options even when in-person services would be more effective (AMN Healthcare, 2021; Jacobs et al., 2004). Interpreters are often excluded from clinical decision-making and discharge planning, leaving patients unclear about diagnoses or next steps (Karliner, 2021). Despite strong evidence showing that interpretation improves safety and trust, many hospitals remain underprepared for the needs of a rapidly growing population. The U.S. Spanish-speaking population has grown by 233% since 1980 (Lopez & Gonzalez-Barrera, 2013), yet interpreter systems have not scaled to meet demand.

Literature Review

Language access in healthcare is mandated under federal law. Title VI of the Civil Rights Act prohibits national-origin discrimination, and Section 1557 of the Affordable Care Act requires hospitals receiving federal funding to provide qualified interpretation (AMA, 2017; DOL, n.d.). Many facilities meet only minimal compliance. Allar & Ortega (2021) note hospitals often treat interpreter services as a cost burden, leading to underinvestment and weak enforcement.

Modality matters. Jacobs et al. (2004) and Comparing In-Person, Video, and Telephonic Medical Interpretation show that in-person interpretation is significantly more accurate and fosters greater patient trust than video remote interpretation (VRI) or over-the-phone interpretation (OPI) (Locatis et al., 2010). Providers rated in-person interpretation 0.32 points higher (4.90/5) than phone (4.58/5), and interpreters reported an even larger gap (Locatis et al., 2010). AMN Healthcare (2021) adds that 56% of hospitals cite cost as the reason for not using in-person interpreters despite acknowledging its quality advantages. However, Medicaid allows states to claim federal reimbursement for interpretation services—either at the standard 50% rate or up to 75% under the Children's Health Insurance Program Reauthorization Act (CHIPRA)—if costs are filed as administrative expenses (Translation and Interpretation Services | Medicaid, n.d.).

Cultural competency drives trust. According to the AP-NORC Center of Research (2017), 49% of older Hispanics report communication difficulties with providers, and 57% struggle to find one who speaks their language. As a result, only 16–20% of older Hispanic adults trust that long-term care services—such as nursing homes or home aides—will understand and respect their language preferences, family dynamics, and cultural values around care. Through the Eyes of Spanish-speaking Patients found that using family members or untrained staff as interpreters undermines accuracy and confidence (Nguyen et al., 2024).

Staffing gaps deepen inequities. Though some hospitals successfully integrate interpreters into care teams (CMS, n.d.), most rely on unmonitored virtual tools (AMN Healthcare, 2021). In one case, "intoxicado" was misinterpreted as "intoxicated" instead of "poisoned," delaying treatment and leading to a $71 million malpractice settlement (Van Kempen, 2007).

These barriers—underfunding, misused modalities, cultural gaps, and staffing shortages—form the backdrop for this study, which examines how Georgia hospitals' systemic decisions perpetuate language access inequities.

Methods

This research used a mixed-methods approach to explore systemic barriers to interpretation. Three types of data collection were used:

1. **Interpreter Survey (n=20):** Licensed Spanish-English medical interpreters from four Georgia hospital systems completed a survey with Likert-scale, multiple-choice, and open-ended questions on modality usage, training, staffing, workflow, and cultural competency. A 10-point scale was used for nuanced ratings like usage and effectiveness; 5-point Likert scales were used for satisfaction and agreement. Questions were informed by existing literature and national best practices.

2. **Provider Survey (n=5):** Three providers and two residents from a major hospital were surveyed about interpretation preferences, access barriers, and communication errors. They were selected through convenience sampling based on availability and experience with Spanish-speaking patients in Georgia. The survey focused on quality, access, and trust-related outcomes.

3. **Hospital Administrator Interviews (n=4):** Hospital leaders overseeing language services, including directors of Patient Experience and Language Access Services, were interviewed from four major Georgia health systems. Semi-structured Zoom interviews lasted 30–45 minutes and explored interpreter funding, staffing, workflow integration, cultural competency, and compliance practices across departments.

Surveys allowed for efficient data collection across diverse participants, while interviews provided deeper insights into policy, funding, and structural challenges. Survey data were analyzed in Excel. Interviews were transcribed and coded using grounded theory to develop themes. Findings were cross-compared across all three sources and supported by national literature.

Results

Interpreter Survey Findings

Analysis of feedback from 20 Spanish-English medical interpreters working across Georgia hospital systems reveals systemic barriers affecting language access for LEP patients. Five themes emerged:

1. **Modality Use and Effectiveness**
   Interpreters reported heavy reliance on over-the-phone interpretation (OPI) despite rating it the least effective. Mean usage scores (1–10) were OPI: 8.11, video remote interpreting (VRI): 6.95, and in-person: 6.2, yet effectiveness ratings favored in-person (9.26) over VRI (8.42) and OPI (7.16). One interpreter noted:

   "There are complaints about VRI or OPI interpreters being unavailable or unreliable."

2. **Institutional Support and Staffing**
   Only 4 of 20 respondents felt their hospital had enough interpreters, and 16 reported shortages. Tracking of language demand was rated at 5.58/10, and integration into clinical teams scored just 2.95/5. One interpreter explained:

   "Sometimes I'm asked to stay longer than anticipated to meet an unexpected need or help with a high volume of requests."

3. **Training, Recognition, and Career Development**
   Although 16 interpreters had adequate medical terminology training, only 11 received ongoing education and just 10 were trained in Spanish dialect diversity. Nearly all (18 of 20) believed structured career paths would reduce burnout, yet only 4 hospitals had policies addressing it:

   "This [burnout] is not a consideration for companies or hospitals."

4. **Cultural Competency and Patient Safety**
   Although most interpreters felt culturally prepared, misunderstandings were still common (mean 3.63/5). Many had witnessed errors due to lack of interpretation, and over half admitted to making mistakes that affected care. One recalled a virtual interpreter being used during an end-of-life discussion; the next day, the patient was extubated, and the family—believing oxygen had been promised—felt blindsided and betrayed.

5. **Overreliance on Virtual Modalities**
   Most interpreters (14) believed virtual interpretation harmed outcomes, citing poor audio/video quality, inability to read body language, and technology failures:

   "Connectivity and audio can be an issue."

Provider Survey Findings

Analysis of five Georgia-based providers' responses highlights clear alignment with interpreter concerns:

1. **Modality Preferences and Accuracy**
   Four of five providers preferred in-person interpretation and unanimously rated it as the most accurate:

   "Live person interpretation helps bypass potential audio visual issues… communication is not only verbal but can be inclusive of body languages."

2. **Access and Availability**
   Access to interpreters remains inconsistent. One provider reported "never" having trouble arranging interpretation, one "rarely," two "sometimes," and one "often." Another said:

   "We should have more in-person interpretation."

3. **Quality and Safety Concerns**
   Two of the five respondents had witnessed medical errors due to miscommunication, and three reported experiencing miscommunication themselves. One wrote:

   "In person communication in my opinion out weight vo/ip methods."

4. **Ad-Hoc Interpretation**
   Despite federal policy discouraging family-member interpreters, *four* of five providers admitted using them when professionals were unavailable:

   "It's against hospital policy to rely on family members," one explained, but shortages often forced this workaround.

5. **Trust and Patient Confidence**
   Four providers believed patients trust clinicians more when professional interpreters are present:

   "When a medical interpretation service is used, it helps build confidence."

6. **Recommendations**
   Suggestions for improvement included increasing in-person interpreter access, better utilization protocols, and basic medical Spanish training for providers. One noted:

   "I would like to increase physician utilization in calling interpreters… this would allow us to get more full-time employees."

Hospital Administrator Interview Analysis

Four semi-structured interviews with Georgia hospital language services directors revealed consistent barriers across interpreter delivery, staffing, cultural competency, and policy. All hospitals confirmed virtual interpretation (VRI and OPI) is the default, primarily due to cost and scheduling ease, even though they acknowledged face-to-face services yield better patient understanding and trust. Health system 3 stood out with 14 full-time interpreters and a Qualified Bilingual Staff (QBS) program leveraging over 100 certified bilingual employees to help with overflow. Yet even this hospital admitted rural and satellite campuses remain underserved. Health systems 1, 2, and 4 cited thin staffing as their biggest challenge and described relying heavily on virtual tools, sometimes summoning interpreters late in the clinical process.

Cultural competency initiatives varied. Health system 3 reported weekly interpreter huddles focused on dialect awareness and cultural behaviors, while others acknowledged a lack of formal training for providers. Dialect was flagged as a frequent cause of miscommunication, especially among Central American populations.

Data tracking and policy enforcement were a shared weakness. Hospitals admitted interpreter use is not consistently documented, making it hard to justify staffing increases or pass Title VI and ACA Section 1557 audits. Health system 3 hopes to centralize data to expand staff, while health systems 1 and 2 propose medical Spanish training and stronger incentives for full-time interpreters. While promising programs like QBS and cultural huddles exist, all hospitals face structural barriers—limited budgets, fragmented data systems, and leadership gaps—preventing sustainable language access.

Discussion

This study reinforces a troubling national pattern: hospitals prioritize cost and efficiency over communication quality. Virtual interpretation is overused in scenarios where in-person care is critical (Locatis et al., 2010; AMN Healthcare, 2021). Both interpreters and providers view in-person interpretation as the gold standard, yet staffing shortages and poor data tracking mean virtual methods dominate.

Staffing deficits drive this cycle. Hospitals underestimate interpreter demand, framing it as ‘unpredictable’ rather than using available data. This causes burnout, ad hoc interpretation, and underinvestment. (CMS, n.d.; Jacobs et al., 2004). Without sufficient staff, interpreters are often utilized late in the care process or excluded from care planning.

Cultural competency remains inadequate. Interpreters report that providers miss cultural cues. Hospitals lack structured training programs to address this, undermining patient trust and engagement.

Hospitals are bound by Title VI and ACA Section 1557, but penalties for noncompliance are minimal because enforcement relies on patient complaints and rarely results in corrective action (Van Kempen, 2007; Haldar, Pillai, & Artiga, 2023). Language access will remain a checkbox until accountability improves

Recommendations:

1. Establish data tracking for interpreter use in electronic health records.
2. Expand full-time interpreter positions, especially for Spanish.
3. Integrate interpreters into care teams via clinic huddles and rounds.
4. Provide cultural competency training and career advancement pathways.
5. Tie accreditation and reimbursement to documented language access efforts.

Conclusion:

Interpreters and providers agree: current systems are failing Spanish-speaking LEP patients. Hospitals must treat interpretation as central to quality, safety, and equity—not as a peripheral expense. Sustained investment, integration, and accountability are needed to close the gaps that jeopardize patient care.

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Conflicts of Interest

The author declares no conflicts of interest related to the research, authorship, or publication of this paper.