

Building Capacity of Interpreting Services in Australian Healthcare Settings: The Use of Video Remote Interpreting During the COVID-19 Pandemic

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Abstract

Confronted with a crisis of unprecedented scale in the second quarter of 2020, Australian States and Territories had to adopt crisis management strategies to ensure equitable access to services are guaranteed for all communities. In this context, and because face-to-face interpreting was no longer an option for each consultation, clinics, hospitals, and GP practices were urged to resort to remote interpreting, i.e., the use of technologies to gain access to an interpreter. After setting the Australian healthcare interpreting scene against historical milestones, this article discusses the usability of Video Remote Interpreting (VRI) in Australian healthcare settings, the way the demands for this new modality were met, as well as the perceptions of participants involved in remote communication. Findings from a mixed method study are presented and discussed. The data collected through surveys and interviews aimed to identify how and if the use of VRI proved efficient, and if this modality was expected to replace onsite and telephone interpreting and to what extent. The outcomes showed a shift from Telephone Interpreting to Video Remote Interpreting as the preferred remote modality, though onsite interpreting remains the preferred modality of the participants involved in the communication exchange.

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1. Introduction

In the face of the COVID-19 pandemic, new demands in Translation and Interpreting (hereafter T&I) services forced interpreting service providers in Australia to adapt quickly to the new communication requirements while respecting the national lockdown measures, thereby directly impacting interpreters in their professional practice. The restrictions to international travel put in place by the Australian Health Protection Principal Committee (AHPPC) as early as March 2020, greatly impacted every sector of the economy, and services in particular. These decisions were then followed by lockdown measures implemented differently in States and Territories, with a longer and stricter lockdown period from August 2020 onwards in Victoria as the State was driving the tally of new cases. One year later, in July 2021, both the Greater Sydney region and the State of Victoria were forced into lockdown again to respond to high transmission of the Delta variant, impacting the everyday lives of 12 million people, i.e., approximately half of Australia's population.

As part of the *Guidance for Health Service Organisations* published by the Australian Commission on Safety and Quality in Health Care (NSQHS), a Risk Management Plan was adopted to mitigate the risk of COVID-19 transmission. Screening protocols were put in place to protect the workforce, visitors, and patients, including social distancing measures, the obligation to wear masks indoors and sometimes outdoors, using QR codes for checking into public and private spaces, amongst the major measures. These safety protocols varied according to the State or Territory concerned and the latest developments in terms of COVID-19 transmission. Adding to the complexity of preparedness measures is the very nature of medical interactions, which demand the respect of personal privacy when communicating, ensuring each individual's rights to access to reliable and timely information is protected. These rights to safe and qualitative health-related information are guaranteed under the *Australian Charter of Healthcare Rights* (2008). Because of such a critical and complex situation, public health policies both at federal and state levels were redefined and adapted to the new landscape.

The Australian 2021 census reports that approx. 300 separately identified languages are spoken in Australia and that more than one fifth (22.3%) of the Australian population speak a Language Other than English (LOTE) at home, peaking at 27.6% in Victoria (Australian Bureau of Statistics, 2022). Consequently, a significant proportion of the users of T&I services in healthcare comes from the various Culturally and Linguistically Diverse (CALD) communities. With the added difficulty of working under changing and constraining conditions, how would the healthcare system cater for the needs of these CALD communities?

In the language industry, the pressing need to offer safe and efficient communication solutions triggered a rapid response from Language Service Providers (LSPs) and language departments within public health facilities and community centers. As the highest demand interpreting services in Australia lies in the healthcare sector (Hlavac et al., 2018a), both the public and private sectors were urged to find alternatives to continue providing services generally delivered face-to-face (also called in-person or onsite interpreting) in healthcare settings while maintaining an equivalent level of quality. This also involved

mandatory compliance with updated working conditions, hence enabling clinics, hospitals, and GP practices to run as smoothly and safely as possible in such unforeseen circumstances.

The crisis sparked by COVID-19 triggered a domino effect on the whole healthcare system, stretching it to a point where stringent restrictions had to be put in place to alleviate the burden on hospitals and clinics and help mitigate any influx of people in intensive care. Interpreters could no longer be called to come and support in person. The obligation to comply with both safety protocols and individual rights translated into the surge in the demand for Remote Interpreting (RI), into the swift adaptation and ramping up of telemedicine services (also called e-health services), and the use of platforms such as *Telehealth* and *Healthdirect* to deliver interpreting services. Onsite interpreting, the preferred modality in the pre-pandemic era, was to be replaced by either Telephone Interpreting (TI) or Video Remote Interpreting (VRI). New markets emerged for language services to be delivered remotely and interpreters also had to adapt quickly to maintain their activity while learning to work differently.

Some of the data collected in the study presented in the sections below showed that the demand for remote services (including VRI) skyrocketed in some areas. For example, figures obtained from Northern Health, a public health facility in northern Melbourne, show that 63% of interpreting requests in the second half of 2020 were made via TI with a gradual switch to VRI once their inhouse interpreters had achieved specific VRI training. At the Royal Melbourne Hospital, VRI appointments increased from 10-15 a month to 100-200 a month, while a large Melbourne-based LSP recorded a record increase of such appointments in that period compared to pre-COVID data. Studies conducted in other countries drew the same conclusions (De Boe et al., 2024; Lazaro Gutiérrez & Nevado, 2022). However, little is known about how such shifts in practice may have affected interpreters' working conditions, the organization of interpreting services within healthcare services, or the LSPs' response to such demands. Over the years, calls for research to be carried out have been made to better understand the efficiency (Jacobs et al., 2018; Kuo, 1999) and practicality of VRI in healthcare practice (Locatis et al., 2010; Pöchhacker, 2016), or the adequate training of interpreters specializing in that area (Hlavac, 2013), and its cost-effectiveness compared to onsite and telephone interpreting (Masland et al., 2010; Kerremans et al., 2018). In an attempt to bridge this gap, this article will present and discuss a study carried out in 2020-2021 to examine how LSPs and in-house language services adapted to meet changing interpreting needs during the COVID-19 pandemic. The project looked specifically at the way changes were implemented at various levels during medical interpreted consultations, and how the use of VRI impacted the delivery of healthcare services, considering potential obstacles to its extended use.

2. Multiculturalism and the emergence of community interpreting in Australia

Australia is a country of immigration, “one of the nations of the New World that [...] attracted millions of migrants to new lands where they would be able to become the builders of new societies” (Ozolins, 1998, p. 8). Awareness of the implied linguistic diversity and possible obstacles to fluid communication pervading many areas of society arose in the early 1970s with the concept of multiculturalism (Koleth, 2010). It occurred at a time when the social-democrat government endeavored to understand the needs of

its ethno-culturally diverse communities and to develop a “policy of multiculturalism based on the desire for social cohesion and for integration of diverse groups of people in the Australian populace” (Hlavac et al., 2018b, p. 2). Among the political realisations catering for the needs of the different ethnic and linguistic groups and ensuring equal access to services for all, it is worth noting the establishment of the first telephone interpreter service in the world in 1973, of various federal grants for T&I services in hospitals from 1974, of the first full-time courses in T&I from 1975, and the creation of NAATI, the National Accreditation Authority for Translators and Interpreters in 1977 (Hale, 2007; Hlavac et al., 2018b; Ozolins, 1998). Such developments allowed for a more structured practice of ‘community interpreting’, a term first coined in the early 1970s (Chesher, 1997). In 1978, the Galbally Report on the Review of Post-Arrival Programs and Services to Migrants shed more light on several existing services: English language teaching programs, establishment of multicultural resource centers, support for the recognition of overseas qualifications via the Committee on Overseas Professional Qualifications, and T&I services, to name a few. It also recommended a focus on two specific areas of language services which are still the main components of community interpreting and T&I training in Australia today: health and law. Particular attention was put on T&I funding requirements, the need for the expansion of T&I services, and the possible applications of such services across public services (Hlavac et al., 2018b). Once endorsed, the Galbally Report also paved the way for the implementation of a National Policy on Languages, highlighting the importance of training for translators and interpreters. A few years later, the Lo Bianco report (1987) was pivotal in highlighting the importance of professionalizing the T&I industry. The Australian Institute of Interpreters and Translators (AUSIT) was born that same year, followed in 1992 by the Australian Sign Language Interpreters Association (ASLIA), as recommended by the provisions made under the Australian Disability Discrimination Act (1992) for deaf people to access services through Auslan (Australian Sign Language) interpreters (Napier & Kidd, 2013). The establishment of codes of ethics, guidelines, and professional standards in the T&I industry largely contributed to creating the framework needed for practitioners to perform their duties as interpreting professionals while offering the best service possible to users, especially in the healthcare sector.

3. Healthcare interpreting in times of crisis

The World Health Organization (WHO) defines the term *crisis* under the broader term of *emergencies* as covering “both preparedness and response (“crisis management”).”¹ In Australia, disaster and emergency management fall under the aegis of States and Territories, and different response plans and guidelines were set up at the onset of the COVID-19 pandemic in accordance with national policy guidelines: *Australian Health Sector Emergency Response Plan for Novel Coronavirus (March 2020)*; *Australian Commission on Safety And Quality in Healthcare -NSQHS Standards, Guidance for health services*

¹. World Health Organisation (WHO), *Glossary of Humanitarian Terms*.
<https://www.who.int/hac/about/definitions/en/>

organisations; *Australian Health Sector Emergency Plan – Management Plan for Aboriginal and Torres Strait Islander Populations*; *Pandemic Plan for the Victorian Health Sector (March 2020)*, to name a few.

The COVID-19 pandemic has proved a crisis of unprecedented scale in modern human history and one which challenged the structure and very definition of the provision of language services across the country, particularly in healthcare. Examining the use of language in emergency situations through a comparative analysis, O'Brien (2018, p. 1) stresses the importance of clarity and accuracy, and “the need for language translation to be a key element of disaster management,” hereby echoing the emphasis put on quality interpretation to ensure basic human rights are not denied as in the context of migrant crises (Schuster et al., 2018). The urgency to respond to the unexpected COVID crisis served as a wake-up call to remind different T&I stakeholders of the importance of ramping up language services to achieve the main objective: protecting each one within the community. Yet, despite the recommendations stressing the importance of equal and equitable access to vital information together with engaging the community to mitigate the impacts of the crisis for people with Limited English Proficiency (LEP), there is no mention in the documents cited above of the way to concretely integrate interpreting needs in communicating information which had to be delivered orally (e.g., a medical consultation), onsite or remotely (i.e., using digital means), in compliance with state-level restrictions.

3.1. The provision of quality and safe healthcare services

According to the Australian Charter of Healthcare Rights (2008), patients using the Australian health system must be ensured to have equal and fair access to services and to reliable health information and care. The charter states that wherever and whenever care is provided, it is of high quality and is safe. This focus is also why the National Safety and Quality Health Service Standards (2017) were set, to protect “the public from harm and to improve the quality of health service provision” (NSQHS Standards, 2017).

Interpreting in healthcare settings may pertain to either medical consultations, hospital settings or private practice (Hale, 2007), and may be requested in a large spectrum of specific medical contexts and domains, requiring both an understanding of the fields concerned (e.g., anatomy, physiology) as well as of the medical terminology involved (Crezee, 2013). This need for an additional level of specialized knowledge in specific contexts is echoed by Eser who describes community interpreting as “truly interdisciplinary in that it takes place within the context of other professional settings” (Eser, 2020, p. 21). Specific training on what interpreting in medical contexts involves is therefore to be encouraged to ensure interpreters working in healthcare hold this knowledge of specialized terminology on top of their interpreting skills and provide the highest possible quality in their services. It is with a view to responding to such needs for specialization for interpreters that NAATI developed a specific Certified Health Specialist Interpreter credential in its 2018 new scheme of certifications tests. The ability to provide remote interpreting services is also part of the palette of skills interpreters need to master when working in the healthcare sector. In this respect, under the Australian Commission on Safety and Quality in Health Care standards, Action 2.8 states that the “Australian Government’s Translating and Interpreting Service (TIS National) can supply phone and onsite services”, echoing the *Australian Charter of Healthcare Rights* (2008): “Interpreter

services ... provided in person or by phone” (Beagley et al., 2020, p. 117), but not mentioning other possible modalities. However, it is worth noting that no specific information on how to prepare for the quality provision of such services (training of interpreters and users, technical requirements etc.) is to be found in any of these frameworks and response plans.

3.2. Remote interpreting in healthcare settings: From telephone to video remote interpreting

Interpreting services are fully part of the provision of healthcare and, when onsite interpreting is no longer an option, resorting to remote interpreting (RI) is a convenient way of ensuring the continuity of services. There are many definitions of RI, also called Distance Interpreting (DI) (Braun, 2020), but they all concur that RI is a meeting modality where the interlocutors do not meet in person and where the interpreting is performed via media (telephone, internet). Generally, the interpreter is not physically present during the exchange and performs from a remote location.

Telephone Interpreting (TI), or over-the-phone interpreting (Braun, 2015), is one of various modalities comprised under the term of Remote Interpreting (RI). It is an audio-only modality and can be defined as follows: “Telephone interpreting refers to situations in which the interpreter works over the telephone, without seeing one or either of the two primary parties in the communicative event” (Lee, 2007, p. 231). TI has been strongly linked to community interpreting since the 1970s (Braun, 2015), especially within hospitals and clinics where onsite interpreting staff could provide such services internally. Until the pandemic hit, figures showed that TI was the preferred and most used modality in healthcare after onsite interpreting (Braun, 2015). In Australia, TI has existed since the early 1970s and language service providers and interpreters are familiar with its use. Research findings show that when providing Remote Interpreting (RI) in healthcare in Australia, Telephone Interpreting is the most predominant and most used modality (Ozolins, 2011; Locatis et al, 2010). Yet, and despite its accessibility, it has been observed that TI is not always the preferred option when face-to-face exchanges is not possible. In his 2007 study, Rosenberg cast light on the many challenges TI poses in comparison with in-person interpreting, especially in regard to situational factors. In a face-to-face exchange, the interpreter sees the speakers and deciphers part of the meaning from the non-verbal cues, and TI clearly proves an obstacle in that regard (Connell, 2006; Lee, 2007). In TI, communication mismatches are difficult to resolve, while they are generally overcome in face-to-face situations (Määttä & Wiklund, 2024). Another obstacle posed by, but not limited to TI, is the possibility of a technical glitch, hence slowing down or even impeding communication. Ozolins (2011) adds that, for years, the high cost of telephone calls also proved an obstacle for a wider use. On this note however, and in addition to its ease of use, TI has benefitted from the rapid development of internet use and proves less costly nowadays than booking an interpreter for in-person meetings, especially when organized via call centers (Masland et al., 2010). Despite its obvious advantages, TI does have limitations. Wang (2018) stresses the dissatisfaction of Australian interpreters with this medium, as evidenced through a survey of 465 interpreters, and recommends that all parties involved in the interpreter-mediated communication work together towards setting new protocols with the view of improving the TI experience at all levels. These challenges and recommendations are echoed by Cho (2023) who also points out the need to increase awareness among healthcare professionals on the

status, role, and needs of telephone interpreters. This growing discontent with TI has led to the exploration of another modality associating image on top of sound, heralding the progressive use of Video Remote Interpreting (VRI).

The earliest documented multimedia experiment on Remote Interpreting (RI) using satellite transmission of both image and sound was undertaken in 1976 by UNESCO, with the interpreters based in Paris and the conference center in Nairobi (Mouzourakis, 1996). With the rapid rise of new technologies, remote interpreting modalities slowly evolved from TI (audio-only communications) to video-communicated exchanges, thanks to the development of the Integrated Services Digital Network (ISDN). However, these early explorations faced some obstacles in terms of bandwidth and audio quality and, for years, did not meet the quality standards required by the T&I profession (Böcker & Anderson, 1993). Exploring options via videophony in conference interpreting, Böcker and Anderson (1993) described Video Remote Interpreting (VRI) as a modality enabling the interpreter to work while being physically absent from the conference site and put forward the advantage it presents in terms of travel requirements, arguing VRI is particularly suitable for last minute assignments, when organizing the interpreter's trip is no longer possible. Other advantages over TI would be the possible visual access to non-verbal cues and the more dynamic engagement of the participants.

In an era when digital access to both sound and image has become mainstream, VRI could be promised a bright future, particularly in tele-healthcare. Taking these factors into account, it was not surprising to see LSPs and hospitals' in-house language services switch to VRI from the very onset of the COVID-19 pandemic, in an attempt to ensure the safest and most efficient care for parties involved in healthcare communication. As mentioned earlier, a record increase in the use of this modality have been reported by several institutions or providers in 2020. However, though remote interpreting (both TI and VRI) are seen as worthy solutions when facing unexpected crises and language needs (Skaaden, 2018), performing through VRI still remains quite a novel and difficult exercise for interpreters and medical staff, and the use of this modality is not as widespread as one could imagine.

It is against this background that the study presented in the section below was designed and carried out, with a view to providing evidenced-based information on the usability of the VRI modality, as well as identifying potential obstacles to its wider use and making recommendations for better future integration and application in health facilities.

4. The study

4.1. Rationale and method

The aim of the study was to investigate how VRI was implemented in healthcare facilities when the COVID-19 pandemic broke out and lockdowns were put in place across different Australian states, and more precisely how it impacted working conditions of interpreters and medical staff, how LSPs and internal language services managed such an implementation, what its potential benefits and disadvantages

were compared to other modalities and, finally, what obstacles, if any, hindered its wider use in the provision of healthcare services. The study was carried out via exploratory and descriptive research, quantitative and qualitative approaches, with data collected through surveys/questionnaires and interviews.

Questionnaires targeted at professional interpreters with experience in the healthcare sector and at medical staff aimed at eliciting how they prepared and adapted to changes in their working habits and conditions, and in the management of their workflow, and what their perceptions and sentiments about remote modalities were. The respondents to the questionnaires were, on the one hand, NAATI certified interpreters with a minimum of one-year experience in healthcare interpreting; on the other hand, healthcare professionals with experience in working with interpreters before and after the pandemic broke out. It was anticipated that the data collected could inform future application and better integration of such modalities in healthcare.

Interviews of interpreting managers in charge of the overall running of operations in LSPs and hospital language departments were conducted to gather pre- and post-pandemic information on the management of the provision of interpreting services, be it when using in-house interpreters or external casual ones. Large hospitals in Australia often employ a fixed team of in-house interpreters, especially for the most in-demand languages. When an interpreter for a specific language cannot be supplied internally, they rely on casual interpreters generally provided by LSPs. A particular focus of the interviews was put on the benefits and possible limitations of one interpreting modality over another, as well as on their technical and logistical practicality. Participants in the interviews were from language service departments in hospitals in Victoria or language service providers in Victoria and New South Wales.

The study (data collection and analysis) was carried out between September 2020 and September 2021. It received Macquarie University Ethics approval number 52021928324745.

4.2. Data collection

4.2.1. Questionnaire to interpreters

The questionnaire targeted interpreters with experience in healthcare settings. The proposed study was introduced and circulated via the AUSIT newsletter in early June 2021, and the link to the LimeSurvey questionnaire was active from 15 June 2021 to 01 August 2021. The questionnaire was also disseminated thanks to the support of LSPs and in-house language services departments in hospitals mostly located in Melbourne, Victoria. The professional audience targeted were interpreters of spoken languages with an experience of minimum one year. The level of NAATI certification required to participate was Certified Provisional Interpreter or Certified Interpreter to ensure the professionals participating in the survey were trained practitioners as some of the questions pertained to their experience on the field and would prove useful to shed light on any potential adjustments they might need to implement based on their professional knowledge and perception.

The questionnaire consisted of a total of 28 questions organized under four categories: interpreter profile, impact of the pandemic, working conditions, and interpreter views. To obtain data on similar aspects pertaining to the delivery of interpreting services, the set of questions was also reflected, with some adjustments, in the questionnaire to healthcare professionals as well as in the interview questions (see sections below).

A total of 226 interpreters (n=226) took part in the study. Some questions focused on quantitative content (percentages and numbers) while others called for attitudinal responses about respondents' views and perspectives and allowed for some subjective data to complement the objective information collected under the same section. Furthermore, in some cases, the possibility was offered to participants to add their own input as an alternative to proposed answers, which could allow the capture of information on other aspects of VRI in healthcare settings. The completion rate of the entire questionnaire was 78.3% (n=177).

4.2.2. Questionnaire to healthcare professionals

The second questionnaire targeted professionals working in healthcare settings with experience in working with interpreters. Their roles or positions would pertain to the delivery of healthcare services and could comprise nurses, clinicians, surgeons, among others. These healthcare professionals worked for hospitals and clinics in NSW and Victoria and would at times be involved in interpreted exchanges when dealing with a CALD patient. Respondents could complete the 29-question survey through LimeSurvey, following the same procedure as the surveyed interpreters.

Contacts were established to share and circulate this study within healthcare institutions. The questionnaire was accessible from 18 June 2021 to 24 August 2021. Unfortunately, a few obstacles led to a significantly low number of participants (n = 5); the main one being in-house ethical requirements of hospitals. The timeline of the clearance process requested by internal ethics committees was generally going over the timeline of this study. Also, some feedback indicated it was difficult for respondents to access the online questionnaire from their workstations because of the (legitimately) strict firewall/internet access imposed on staff working in hospital settings, as was confirmed later by interviewees working in hospital language departments.

After the initial two questions on the healthcare professional's profile, the main focus of this questionnaire was on the operational side of interpreting services, the equipment involved and VRI platforms used, the feedback received in-house, and the respondents' professional opinion and perspective. The overall completion rate is 100 % for 5 participants.

4.2.3. Interviews

The choice of a cross-sectional approach to capture a 'screenshot' of what happened when all the management of interpreting activities were put to an abrupt halt at the onset of the pandemic in March 2020, coupled with a longitudinal approach to observe the period from then until mid-2021, was made to

gather and infer from observations stemming both from the public sector (hospitals) and the private sector (LSPs). In this regard, a series of structured interviews were organized with managers of interpreting services sharing their experiences in the field, with a specific focus on the provision of services through VRI. Interviewees who took part all have a long experience spanning from 12 years to more than 30 years in healthcare interpreting management, either as coordinators working in hospitals and clinics, or within LSPs.

A total of six 45-minute interviews were conducted in September 2021. Two Melbourne-based LSPs, three hospital language service departments, and one governmental agency agreed to take part in this process. A series of 38 questions were prepared with the two research questions in mind. The use of the same set of questions aimed to reduce the margin for bias responses as much as possible while collecting data that was subjective. A Participant's Information and Consent Form was communicated to the interviewees a few days prior to the interview, to allow them to understand the objective and the scope of the study. The interviews were conducted on the Zoom platform. The questions were grouped into four main categories: General questions, VRI training, interpreting in healthcare settings, and potential obstacles to the use of VRI.

5. Findings and discussion

Before looking at the findings and discussing them, it is important to recall that the use of VRI and TI varied on the level of lockdown restrictions in place. At level 4, the highest level of restrictions enforced in Victoria as soon as August 2020 and throughout the three lockdowns to follow in that State alone, as well as in NSW mid-2021 for 15 consecutive weeks, no onsite interpreting could be provided except in Emergency Departments where only in-house interpreters fully equipped with Personal Protective Equipment (PPE) were authorized. This scenario therefore only applied to hospitals and clinics who did have in-house interpreting staff to meet their internal needs. As confirmed by managers during the interviews, it is also worth noting that VRI was already suggested as an alternative solution before the health crisis of 2020- 2021. Several trials were carried out both by LSPs and by language interpreting departments in hospitals. When the pandemic hit, healthcare services could not be brought to a halt and a solution had to be found to maintain a satisfying level of care. The projects which were already in the pipeline to offer VRI then proved very useful and, under urgent pressure, increased in volume.

The following sections present a summary and a synthesis of the findings from the responses to the two questionnaires and from the interviews, as well as a general discussion. Full details on each survey questions and interviews can be found in the full report of the research project (Bachelier, 2022).

5.1. Use and perceptions

5.1.1. Interpreters' experience and volume of work

Introductory questions aimed at outlining the general profile of participating interpreters focusing on their overall interpreting experience and their experience in interpreting in healthcare settings. The findings show that 63% of respondents had more than 10 years of experience, 15% between 6 and 10 years, and 22% between 1 and 5 years. All had experience with interpreting in healthcare settings and interpreters with more than 10 years of experience were those with the highest percentage of work in healthcare (54% of their assignments). For those with less experience, working in healthcare settings counted for about 25% of their time on average.

5.1.2. Impact of the pandemic on VRI use

Other questions aimed at understanding how the pandemic affected the interpreters' work overall with a focus on the type of assignments performed before and during the pandemic, the experience of interpreters in VRI or TI. The responses to the question about the pre-pandemic type of assignments showed that 15% of interpreters worked only or mostly onsite, 26% equally onsite or remotely, 46% mostly remotely, and 13% only remotely. As for their experience in remote interpreting, about half of the respondents (48.3%) had pre-pandemic experience working in both TI and VRI, 38% only in TI, and 7% only in VRI.

As previously discussed, the shift to remote interpreting was obvious during the pandemic. The use of TI increased from 21% in 2019 to 42% and 39% respectively in 2020 and 2021. The data collected about the proportional use of VRI before and during the pandemic showed that VRI use increased from 0% in 2019 to 2% in 2020 and 5% in 2021. Though 5% may seem low it meant an increase of 100% or more in various hospitals, as reported by managers of interpreting services. Interpreters noted an increase of 68% on average in the use of VRI in healthcare assignments.

5.1.3. Working conditions

Several questions aimed to identify the devices used by interpreters when delivering their services remotely and the length of the average VRI assignment. The respondents were asked to select which platforms they were using when performing VRI. A number of pre-selected options were available as well as a comment section to allow for any further information in this regard. The Zoom platform tops the list, followed by Microsoft Teams and Cisco Webex. Telehealth, Healthdirect, and the platform used by Multicultural NSW are the three 'other' platforms mentioned by the respondents.

In terms of equipment, 85% of the respondents reported they were not provided with any image-supported device to deliver their service by the LSPs or hospitals. When asked about the settings for the delivery of their service, 85% of respondents indicate they work from home and only 11% mention working from a

hub. As for their impressions regarding the length of VRI assignments compared to onsite ones, 47% of interpreters felt the duration was similar, but 38% believed VRI assignments were shorter.

5.1.4. Interpreters' views on VRI and on-site or telephone interpreting

A total of 14 questions were proposed to gauge the views of interpreters on the VRI modality compared to the two other modalities. Interpreters expressed a preference for onsite interpreting compared to remote (56% vs 43%), mainly because of better remuneration and the sentiment to offer a more personal service. This sentiment was echoed by healthcare professionals and managers of interpreting services. VRI was preferred to TI (52% vs 47%), primarily because of the audio-only nature of TI, which can be a serious obstacle to clear communication in case of poor sound input, patient's strong accent, or even specific technical content, VRI offering the possibility to infer some meaning from visual cues.

5.2. Opportunities, challenges, and future outlook

5.2.1. Benefits and advantages

The responses showed the VRI modality offers a number of advantages for healthcare interpreting. VRI allows healthcare providers to connect with qualified interpreters regardless of their geographical location, especially for geographically dispersed patients, ensuring timely access to interpreting services. A broader pool of interpreters with potentially higher NAATI credentials can be accessed, potentially improving the quality of the service provided. It also eliminates the need for interpreters to travel to hospitals and clinics, saving time and costs, and allows them to accept more assignments daily. Managers noted that VRI can help streamline workflow for hospitals and LSPs, allowing them to handle more bookings and manage a wider range of languages more efficiently. Respondents repeatedly mentioned that visual cues are crucial for effective communication (e.g., non-verbal communication, turn-taking, interaction management), especially when tasks like sight translation have to be undertaken.

5.2.2. Challenges and obstacles

The study shows that, while VRI offers increased accessibility and convenience, it is not without its challenges. The main obstacles to the use of VRI, as perceived by the interpreters, include the higher risk of bad input with VRI (45.45%), more coordination effort prior to the assignment (42.78%), and internet access (41.18%). Interpreters reported finding VRI sessions more cognitively demanding than on-site interpreting due to factors like limited non-verbal cues and potential technical issues. These technical issues included poor internet connection, inadequate Wi-Fi, and lack of proper equipment for interpreters in some hospitals, with visibility and/or audibility issues often hindering the smooth flow of VRI sessions. Additionally, long waiting times before connection and limited opportunities for pre-session briefings were reported by interpreters, potentially impacting the quality of interpreting services. Furthermore, some healthcare professionals expressed concerns about privacy, confidentiality, and family member involvement during VRI sessions, leading them to prefer on-site interpreting when feasible. This concern

was recently echoed in an international study carried out by CSA Research (CSA Research, 2023), which reveals trust levels by users of interpreting services for different interpreting sources. Full trust was placed in face-to-face interpreting (78% of respondents), while confidence in remote interpreters dropped to 56%.

5.2.3. Training and support

While most interpreters received some form of VRI training before or during the pandemic, many expressed a need for further training to enhance their skills and address specific challenges encountered during VRI sessions. Hospitals and LSPs adopted various approaches to training, including providing internal guidelines, protocols, and webinars. However, the study emphasizes the need for more comprehensive training programs that address the following specific areas: Technical aspects of VRI platforms and troubleshooting common technical issues (e.g., choice of audio and video equipment, connectivity requirements); ethical considerations specific to VRI, including data privacy and confidentiality; effective communication strategies for VRI sessions, focusing on maximizing non-verbal cues and establishing clear communication protocols.

5.2.4. Perceptions on the future use of VRI

The responses from both interpreters and providers suggested that VRI would likely play a continued role in healthcare interpreting even after the pandemic would subside. However, for a future use of the modality to be sustainable and optimized, usage requires addressing the identified challenges. This could be achieved through investing in reliable technology and providing adequate equipment for interpreters to ensure seamless VRI sessions; developing comprehensive training and support programs for both interpreters and healthcare professionals to enhance their skills and address ethical considerations specific to VRI; streamlining booking processes and minimizing waiting times to improve efficiency and patient experience; emphasizing the importance of pre-session briefings and establishing clear communication protocols to ensure effective delivery of interpreting services. Furthermore, several participants insisted on the fact that striking a balance between the use of VRI and on-site interpreting is crucial. Given the preference of most respondents for onsite interpreting, healthcare professionals and LSPs should consider patient needs, preferences, and specific situations when determining the most appropriate mode of interpreting.

The study also highlighted the need for further research to explore the long-term impacts of VRI. The focus of future studies could be on interpreter well-being and potential for burnout due to increased cognitive demands; patient and client satisfaction with the quality of interpreting services received through VRI, also in comparison with telephone interpreting for example; healthcare outcomes and potential impact of VRI on communication clarity and patient understanding. Additionally, exploring innovative solutions like hybrid models combining VRI with onsite support for complex situations could be beneficial in ensuring effective communication and optimal healthcare delivery for all patients.

6. Conclusion

In this article, we have examined how medical interpreting changed during the COVID-19 pandemic, specifically focusing on the adoption of Video Remote Interpreting (VRI) in Australia. After reviewing historical milestones in the development of interpreting services in the country and the pre-pandemic situation regarding the provision of language services in the healthcare sector, this article presented and discussed the findings of a study that aimed at assessing the usability of VRI and its implementation in a crisis situation, as well as eliciting the perceptions and preferences of participants involved in remote communication.

While the COVID-19 pandemic has significantly impacted healthcare delivery, it has also accelerated the adoption of VRI as a valuable tool in healthcare interpreting, surpassing telephone interpreting in popularity. While VRI offered advantages in specific situations, most participants expressed a preference for onsite interpreting due to the enhanced human connection, improved communication, and perceived value it provided for interpreters. VRI brings challenges such as unequal patient access to technology, a lack of standardized platforms requiring interpreters to be trained on various systems, and the potential for reduced care quality due to limitations inherent in remote communication. Various areas for future research on the topic have been identified and include, among other things, the need to assess the impact of VRI platforms or of assignment duration on the health and well-being of interpreters, to investigate the effect of equipment quality on the communication situation and the inherent risks on patients' health in case of failure to properly use the modality. Responses from participants also invited the exploration of additional features to VRI like live captioning and chat boxes and their impact on the quality of interpretation.

By addressing the identified challenges and opportunities, and by ensuring proper investment in digital infrastructure and in training and support for both interpreters and healthcare professionals, VRI has the potential to become a permanent fixture in healthcare interpreting in Australia and to improve accessibility, efficiency, and quality of interpreting services, ultimately contributing to better healthcare outcomes for patients with diverse language needs.

Disclosure statement

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