

Being Heard through another Person's Words: A Qualitative Evidence Synthesis of Interpreter-Mediated Care, Moral Agency, and Trust Among Patients Facing Language Barriers

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Abstract

Language access in healthcare is often evaluated by whether an interpreter is available, yet interpreter presence alone does not establish that a patient's account has been fully expressed, accurately conveyed, or incorporated into clinical interaction. Interpreter-mediated encounters can support participation while also redistributing conversational control, confidentiality, relational continuity, and dependence. To synthesize qualitative evidence on how patients, caregivers, interpreters, clinicians, and other relevant actors experience interpreter-mediated healthcare, with particular attention to patient voice, moral agency, relational trust, and the contextual conditions that shape these experiences. A qualitative evidence synthesis using meta-ethnographic principles was undertaken. Searches conducted on 22 September 2026 identified 90 records through five structured search runs and supplementary citation chaining. After removal of 26 duplicates, 64 unique records were screened; 32 reports were sought, 26 were available for full assessment, and 22 primary qualitative evidence units met the eligibility criteria. Included evidence was appraised using qualitative methodological domains without numerical scoring. First-order participant accounts and second-order author interpretations were preserved separately before reciprocal and refutational translation. Confidence in final synthesis findings was planned using GRADE-CERQual. The included literature showed that interpreter-mediated care was not experienced as a single, uniform intervention. Meaning was shaped by interpreter accessibility, continuity, dialect and linguistic fit, confidentiality, modality, clinician language capability, family involvement, time pressure, organizational workflow, and the extent to which interpreted speech preserved clinically and personally significant detail. Professional interpretation often supported understanding and participation, but residual problems remained when patients perceived information to be condensed, insufficiently contextualized, delayed, or mediated through relationships they did not fully control. Conversely, informal or partial language concordance could sometimes support rapport while introducing other risks. Interpreter-mediated care can enable patients to be heard, but the ethical significance of interpretation depends on whether language support preserves meaningful expression, supports rather than substitutes for patient participation, and operates within trustworthy and usable institutional arrangements. The evidence supports a context-sensitive account of mediated agency rather than a binary distinction between interpreted and uninterpreted care.

Keywords: Medical interpreting, Language barriers, Qualitative evidence synthesis, Patient voice, Moral agency, Relational trust

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Introduction

Language barriers in healthcare are often treated as problems of information transfer, yet patients' accounts suggest a wider experience. Spanish-speaking patients and caregivers in hospital settings have described difficulty understanding what was happening, uncertainty about decisions, and dependence on others

for access to information and participation [1]. Among Nepali migrants in Finland, language barriers also extended into navigation, privacy, practical reliance on social networks, and the ability to manage encounters across an unfamiliar healthcare system [2]. In interpreter-mediated psychotherapy, trust was similarly linked to more than literal translation: patients, interpreters, and therapists described confidentiality, professional conduct, relational presence, and confidence in the interpreted exchange as integral to the therapeutic relationship [3].

Recent cancer-care studies sharpen this distinction between interpreter availability and the quality of mediated communication. Latino patients and caregivers have reported concerns that interpreters did not always convey everything they considered important, particularly where jargon, dialect, or linguistic mismatch complicated communication [4]. Patients and relatives in Danish cancer care described language barriers as an additional burden during already difficult treatment trajectories, while continuity and high-quality interpretation could reduce some of that burden [5]. Observational work in language-discordant oncology encounters likewise found that professional interpretation did not eliminate miscommunication, organizational constraints, or the transfer of communication work to accompanying relatives [6]. These findings make it difficult to treat interpreter presence as a homogeneous exposure or as a sufficient indicator that patients have been able to communicate in ways that preserve their priorities, uncertainty, and reasons.

Broader evidence supports professional language assistance while also showing why effectiveness and lived experience must be distinguished. Systematic and scoping reviews indicate that professional interpreters, language-concordant care, and structured interpretation technologies can improve aspects of communication compared with improvised approaches, although evidence varies substantially by setting and modality [7–9]. Nursing research similarly documents recurrent communication problems where language barriers are present [10]. At a system level, the implementation of trained interpreters is affected by organizational rules, resources, and institutional arrangements rather than by clinical need alone [11]. Consequently, nominal availability may not translate into timely, acceptable, or usable interpretation at the point where patients need to

explain symptoms, ask questions, express preferences, or disagree.

Quantitative and service-level studies demonstrate that language discordance is associated with wider differences in care, but they cannot by themselves establish how those differences are experienced or produced. Hospital clinicians report using mixtures of professional interpretation, informal support, partial language concordance, and pragmatic workarounds in routine practice [12]. Patient-reported research in breast cancer care has identified disparities associated with language barriers [13], while observational research has examined relationships between interpreter-service use and patterns of intensive-care utilization [14]. Such evidence is important for identifying inequity and service consequences, but it does not resolve the interpretive question at the center of this review: how does communication through another person affect what patients can say, how their account is received, and whether trust and practical authority remain attached to them?

This review therefore examines interpreter-mediated healthcare as a relational and institutional phenomenon rather than as a binary intervention. The primary question is: How does qualitative evidence describe the ways interpreter-mediated care shapes patient voice, moral agency, relational trust, and dependence among people facing language barriers, and which contextual, methodological, cultural, or institutional conditions explain variation in those experiences? The analysis preserves distinctions between communication quality, patient agency, trust, and institutional access so that convergence in one domain is not assumed to imply convergence in another.

Materials and Methods

The review was conducted as a qualitative evidence synthesis using meta-ethnographic principles. Reporting of the identification and selection process followed the transparency logic of PRISMA 2020 [15], while the interpretive synthesis was structured according to meta-ethnographic reporting guidance rather than treating PRISMA as a synthesis method [16]. This distinction was necessary because the objective was not to aggregate frequencies or estimate an average intervention effect. The analytical task was to preserve participant meaning, identify concepts that could be translated across studies, retain findings that challenged each other, and develop a

higher-order interpretation only where the primary evidence supported such translation.

Search strategy and eligibility

Searches were executed on 22 September 2026 using five structured scholarly search runs supplemented by backward citation chaining. Search combinations covered interpreter-mediated care, medical interpretation, professional interpreters, language discordance, language barriers, patient experience, qualitative research, trust, agency, voice, participation, clinical communication, language concordance, and relevant clinical settings. The five search runs yielded 86 records, and citation chaining contributed four additional records, producing 90 records before deduplication.

Eligible primary evidence units were published from 2018 through 2026 and reported qualitative data, or a separable qualitative component of a mixed-method study, concerning language-discordant or interpreter-mediated healthcare. Studies could include patients, caregivers, interpreters, clinicians, or other directly relevant healthcare actors when their evidence illuminated the focal clinical encounter. Country and language pair were unrestricted. Quantitative-only reports, reviews, methodological papers, conceptual

articles, non-healthcare settings, and studies in which language mediation was peripheral were excluded from the primary qualitative evidence corpus, although some were retained as background, methodological, or boundary-setting references. Journal quartile was not used as an eligibility criterion for evidence inclusion.

Twenty-six duplicate records were removed from the 90 identified records, leaving 64 unique records for title and abstract screening. Thirty-two records were excluded at that stage. Thirty-two reports were sought for full assessment; six could not be retrieved in sufficient form for complete eligibility appraisal, leaving 26 full reports assessed. Four were excluded at full-text assessment: two lacked a separable eligible qualitative component, one treated language mediation only peripherally, and one was a secondary/context source rather than a primary qualitative evidence unit. Twenty-two evidence units were included in the synthesis.

The complete selection arithmetic is shown in **Figure 1**. **Figure 1** callout. The study-selection process distinguishes the evidentiary corpus used for qualitative synthesis from references retained only for methodological, contextual, or interpretive purposes; the final included-evidence count therefore does not correspond to the manuscript reference-list size.

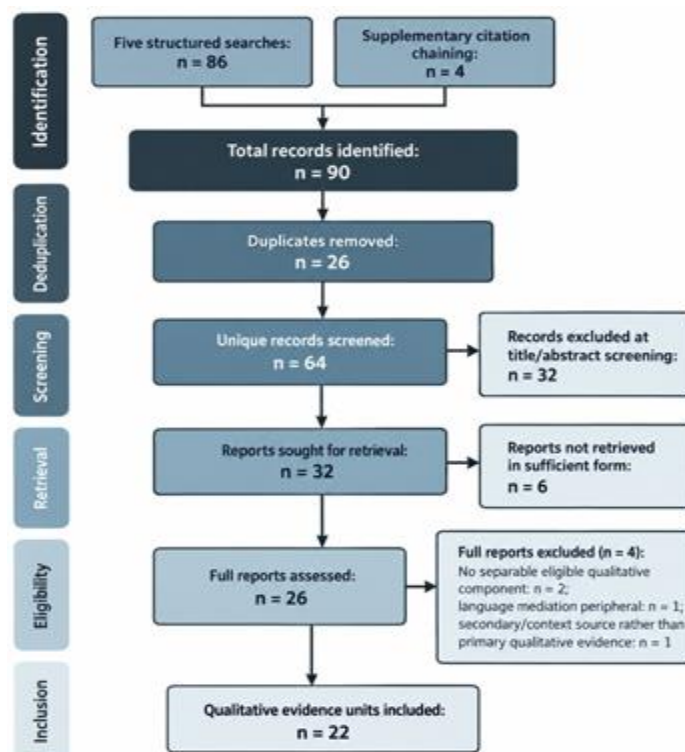


Figure 1. Study-selection flow diagram

Appraisal, extraction, and synthesis

Methodological appraisal was conducted using qualitative appraisal domains without converting study quality into a numerical score or excluding studies solely because of an aggregate appraisal value. The purpose was to determine how limitations in sampling, reflexivity, data collection, translation procedures, analysis, or reporting might affect particular synthesis findings. In the subsequent confidence assessment, methodological limitations were treated as one component of finding-level confidence rather than as a proxy for evidentiary worth [17, 18].

The synthesis proceeded in three stages. First-order data referred to participant accounts reported in the included studies, while second-order data referred to the interpretations offered by study authors. Concepts were then compared through reciprocal translation when studies described substantively comparable phenomena and through refutational translation when findings diverged or exposed different conditions. Coherence was evaluated without requiring uniformity: contextual variation was retained where it could plausibly explain differences across studies [19]. Adequacy was judged according to the richness and amount of contributing

qualitative data rather than by converting the number of studies into a measure of effect strength [20]. Relevance was assessed against the review question, actor group, clinical context, and language-mediation configuration. GRADE-CERQual was reserved for confidence judgments concerning final synthesis findings.

Extraction preserved the distinction between the person whose health and preferences were at stake and the other actors participating in communication. Patient, caregiver, interpreter, clinician, and organizational accounts were therefore not treated as interchangeable evidence. The extraction structure recorded setting, population, mediation form, communication context, focal constructs, mechanisms or processes, contradictory observations, methodological limitations, applicability boundaries, and the exact claim each evidence unit could support. This design also prevented interpreter presence from being treated as a standardized intervention when modality, continuity, linguistic fit, family participation, clinical seriousness, and institutional access differed substantially between studies.

The resulting encounter configurations used to organize the descriptive synthesis are summarized in **Table 1**.

Table 1. Encounter conditions through which language mediation became usable, fragile, or substitutive in the included qualitative evidence

Encounter configuration	Settings and actors represented	What remained available to the patient	How mediation entered the encounter	Contextual variation retained in synthesis	Interpretive caution
Professional interpreter available and actively integrated	Hospital, cancer, psychotherapy, primary and specialist care; patients, caregivers, interpreters and clinicians	Opportunity to explain concerns, ask questions and receive linguistically accessible information	Interpreter functions as a recognized third participant in clinical communication	Continuity, confidentiality, linguistic fit, interpreter role and clinician interaction differed markedly	Availability alone cannot be treated as proof of complete understanding, agency, or trust
Professional interpreter present but linguistically or relationally mismatched	Cancer care, psychotherapy and other specialist encounters	Formal access to translated communication remains present	Meaning is transferred through an interpreter whose dialect, terminology, continuity or relational fit may be experienced as insufficient	Jargon, dialect, cultural familiarity and previous relationship with the interpreter or clinician modify the encounter	Perceived mismatch should not be generalized to professional interpretation as a whole
Informal or family mediation	Migrant, hospital and outpatient contexts; patients, relatives and clinicians	Immediate access to familiar support and sometimes faster communication	Relative, friend or other untrained person contributes to translation, explanation or navigation	Patient authorization, confidentiality, urgency, family relationships and service availability differ	Family participation can support the patient or displace parts of the patient's communicative role; the two should not be conflated
Ad hoc bilingual staff mediation	Nursing and emergency-care settings	Linguistic assistance may become available despite lack	A bilingual clinician or nurse is diverted into an interpreting role	Staffing, professional responsibilities and perceived language	Linguistic capacity does not by itself establish interpreting

		of formal interpreter access		ability affect feasibility	competence or eliminate role conflict
Partial clinician- patient language concordance	Primary and other clinical care	More direct interaction and potential rapport	Clinician communicates using a shared language with incomplete proficiency or limited clinical vocabulary	Topic complexity and clinician proficiency determine when direct communication remains adequate	Rapport gains may coexist with semantic risk; partial concordance is not equivalent to verified proficiency
Remote or video- mediated professional interpretation	Hospital and cross- setting language services	Professional interpreting may become available when in-person access is impractical	Interpreter participates through technological mediation	Availability, privacy, technical reliability and perceived interpersonal distance vary	Remote access can improve availability without reproducing every relational feature of in-person interpretation
Institutionally constrained language access	Multiple healthcare systems and migrant-care contexts	Patient capacity to communicate depends on whether language support can actually be reached when needed	Scheduling rules, staffing, workflow and service policy determine whether formal support becomes usable	Resources, organizational routines and local language-access policy vary between institutions	Nominal entitlement or service existence should not be equated with timely practical access

Results and Discussion

Twenty-two primary qualitative evidence units were included. Their settings ranged across inpatient hospital care, primary care, oncology, psychotherapy, palliative and end-of-life care, cardiac care, emergency care, migrant health, and other language-discordant clinical contexts. The corpus contained patient and caregiver accounts together with studies of interpreters, clinicians, nurses, and multiactor encounters. This actor diversity was analytically useful because communication problems were often located differently by different participants: patients emphasized what they could understand or express, interpreters described the work of transferring meaning, and clinicians frequently emphasized workflow, availability, or clinical efficiency. A first recurring pattern concerned what could be elicited when communication passed through another person. In a multiactor study of broad social-history taking, patients, clinicians, and interpreters described how language discordance, time, formality, and interpreter involvement could affect what information entered the clinical conversation [21]. South Asian patients using interpreting services in English general practice similarly described professional interpretation as valuable but dependent on how accessible and responsive the service was to the actual encounter [22]. Research involving children and young people seeking asylum or living as refugees reinforced the importance of relational and situational context: interpretation affected not only linguistic access but also the practical conditions under which sensitive information could be communicated

[23]. Across these studies, interpretation functioned as part of the interaction rather than as a transparent channel operating independently of the people and setting around it.

A second pattern concerned preservation of the patient's meaning. Conversation-analysis-informed research on pain communication among Hmong patients showed that interpreted renderings could sometimes condense or alter clinically and affectively significant material [24]. Provider accounts from primary care demonstrated that decisions about using interpreters or relying on clinician language ability were themselves negotiated within workflow, proficiency, and practical constraints [25]. Healthcare providers working with migrant patients described a wider repertoire of communicative adaptations rather than a single standardized response to language discordance [26]. Taken together, these studies indicate that language mediation can modify the pathway through which information becomes clinically available even when no participant intentionally seeks to override the patient's account.

Partial language concordance formed a related but distinct configuration. Research in primary care suggests that partial clinician-patient concordance may improve immediacy and rapport while leaving uncertainty about semantic precision when clinical topics become complex [27]. Multistakeholder work with migrant patients, caregivers, and healthcare professionals likewise identified communication needs that differed according to actor role and could not be reduced to one universal support strategy [28]. Nurses caring for Chinese-

speaking cardiac patients described repeated adaptation to language-discordant care, emphasizing that communication work often continues beyond the formal act of interpretation [29]. In palliative and end-of-life care, physicians described language discordance as intertwined with family relationships, cultural interpretation, prognosis, and communication about goals of care [30]. These findings caution against placing encounters on a simple continuum from “no language support” to “successful language support.” The clinically relevant distinction is often whether the form of support remains adequate to the complexity and sensitivity of what the patient is attempting to communicate.

Organizational access was a fourth recurring pattern. Australian research on language-discordant clinical encounters documented uneven access to interpreter services and the practical consequences of that variability for communication [31]. Nurses caring for patients with limited English proficiency similarly described language barriers as constraints on assessment and relational care even when they developed local workarounds [32]. Bilingual nurses acting as ad hoc interpreters reported being pulled between interpreting and their primary professional responsibilities, showing how apparent linguistic capacity can relocate rather than solve institutional communication work [33]. Studies comparing video and in-person interpretation further showed that availability, confidentiality, convenience, technical conditions, and perceived interaction quality influence modality decisions [34]. Thus, organizational arrangements determine which communication options become realistically available at a particular moment.

The final descriptive pattern concerned governance of linguistic capability. Implementation research on language-concordant care has emphasized the need to distinguish a clinician’s self-reported ability from language proficiency adequate for clinical communication [35]. Qualitative research with non-Arab healthcare practitioners caring for Arabic-speaking patients in the United Arab Emirates similarly documented perceived safety and communication difficulties when language discordance persisted in routine care [36]. These accounts extend the problem beyond interpreter availability: healthcare organizations also make implicit or explicit decisions about who may communicate directly, when professional interpretation should be activated, and what forms of linguistic competence are treated as sufficient.

Across the corpus, contradictory observations were retained rather than resolved by simple counting. Professional interpretation was often described as enabling communication, yet not every professionally interpreted encounter preserved meaning equally well. Family participation could provide familiarity and immediate support, yet could also increase dependence or filter what entered the consultation. Partial concordance could improve relational immediacy while introducing uncertainty about technical accuracy. Remote modalities could widen timely access while changing confidentiality or interpersonal experience. These differences provide the empirical basis for the next stage of analysis: interpreting how mediated communication redistributes voice, practical agency, dependence, and trust without assuming that the same relational mechanism operates in every encounter.

Interpretive synthesis of moral agency and trust

The descriptive findings indicate that being heard in interpreter-mediated care cannot be reduced to the successful transfer of vocabulary. Across the included studies, patients’ capacity to participate depended on whether symptoms, uncertainty, preferences, emotional emphasis, and reasons survived mediation in a form that remained recognizable to the patient and clinically usable to the professional. The qualitative systematic review of nurses’ experiences with healthcare interpreters supports this wider interpretation: professional interpretation can improve communication while its effectiveness remains shaped by collaboration, role clarity, accessibility, and the surrounding clinical relationship [37]. The synthesis therefore treats linguistic accuracy as necessary but insufficient for preserving patient voice.

A second interpretive finding concerns control over what enters the clinical conversation. Interpreter mediation can increase a patient’s opportunity to speak while simultaneously redistributing practical control over turn-taking, condensation, clarification, and emphasis. This redistribution is not equivalent to loss of agency. In many encounters it is precisely what makes communication possible. The ethical distinction arises when mediation ceases to function as support for the patient’s communicative purposes and begins to determine which concerns are expressed, shortened, deferred, or treated as clinically relevant. Studies of social-history elicitation, pain interpretation, partial language concordance, and ad hoc staff interpreting illustrate different points at which such redistribution can occur [21, 24, 27, 33].

This distinction is captured in **Table 2**. The rows represent recurrent encounter conditions rather than rankings of interpretation methods.

Table 2. How mediation changes what remains under the patient's control in language-discordant clinical encounters

Mediation condition	Patient voice that remains available	Where control may shift	Relationship to dependence	Trust implication
Responsive professional interpretation	Patient can introduce concerns, questions, uncertainty, preferences and corrections	Interpreter controls linguistic rendering but remains responsive to patient meaning	Dependence on linguistic expertise need not displace decision participation	Trust can deepen when accuracy, confidentiality and continuity are credible
Condensed or insufficiently contextualized interpretation	Core information may be conveyed while emphasis, affect or contextual detail is reduced	Selection and summarization shape what becomes clinically visible	Patient becomes more dependent on another person's judgment about relevance	Trust may weaken if omissions are perceived or discovered
Patient-authorized family support	Familiar assistance may help the patient navigate, remember and contextualize information	Family member may share explanatory or interpretive work	Dependence may be voluntarily accepted and relationally supportive	Trust may be reinforced when involvement reflects patient preference
Family or informal substitution under service constraint	Communication remains possible despite inadequate formal access	Relative or informal helper may become the practical filter for information	Dependence increases because access is conditional on another person's availability and mediation	Confidentiality and confidence in unfiltered communication may become fragile
Partial direct language concordance	Greater immediacy and direct clinician-patient interaction	Clinician decides when personal language ability is sufficient	Reduced interpreter dependence can coexist with dependence on uncertain proficiency	Rapport may improve while confidence in technical precision remains uncertain
Remote professional interpretation	Timely access to professional linguistic mediation can be preserved	Technology and remote turn-taking structure the interaction	Dependence shifts toward service and technical availability	Trust varies with privacy, continuity, technical reliability and perceived interpersonal distance

Trust emerged as relational rather than merely technical. Patients could reasonably trust an interpreter's linguistic ability while remaining uncertain about confidentiality, continuity, dialect fit, or whether their account had been fully transmitted. Conversely, imperfectly seamless communication did not necessarily eliminate trust when patients experienced interpreters and clinicians as attentive, accountable, and open to correction. Relationship-centered communication research further supports treating language and trust as interacting features of a clinical relationship rather than independent variables [38]. The relevant question is therefore not simply whether translation occurred, but whether participants could rely on the communication arrangement to preserve the patient's intended participation.

The synthesis also distinguishes dependence from domination. All interpreted care involves some dependence on another person's linguistic competence. Dependence becomes ethically more consequential when

patients cannot choose among realistic communication options, cannot correct the interpreted account, cannot obtain privacy, or must rely on family or staff because formal language services are unavailable. In those circumstances, institutional scarcity can convert ordinary linguistic dependence into reduced practical control. The same family involvement or bilingual assistance may carry a different ethical meaning when freely authorized than when it is the only workable route to care.

These translated findings support a higher-order interpretation: mediated moral agency is preserved when language assistance expands the patient's effective capacity to express, revise, authorize, and contest what is communicated without transferring practical ownership of the clinical account away from the patient. This is a synthesis proposition rather than a direct statement from any single study. It integrates recurring evidence concerning accuracy, conversational control, confidentiality, correction, family involvement, organizational access, and relational trust.

Confidence in this interpretation was assessed at finding level rather than inferred from study number. **Table 3**

records the resulting confidence judgments and the principal reasons for downgrading.

Table 3. Confidence-qualified interpretive findings on mediated voice, agency, dependence, and trust

Interpretive finding	Evidence pattern	Main contextual variation	CERQual confidence	Principal reason for judgment
Professional interpretation generally expands communicative opportunity but does not guarantee that the patient's full intended meaning is preserved	Recurrent across patient, clinician, interpreter and observational evidence	Clinical setting, dialect, continuity, time and interpreter integration	Moderate	Strong coherence but substantial contextual heterogeneity
Practical agency depends partly on whether patients can introduce, correct and authorize mediated communication	Recurrent evidence concerning disclosure, correction, family participation and conversational control	Actor role and encounter sensitivity	Moderate	Conceptually coherent but agency was usually inferred from qualitative accounts rather than directly operationalized
Trust is shaped by relational features of mediation as well as linguistic accuracy	Recurrent evidence concerning confidentiality, continuity, perceived completeness and relational presence	Psychotherapy, oncology, primary care and modality	Moderate	Rich evidence, but trust was not defined consistently across studies
Informal mediation can either support or constrain participation depending on patient authorization and institutional alternatives	Refutational evidence across family, nursing and access studies	Family relationships, urgency and interpreter availability	Moderate	Direction varies systematically with context rather than showing simple convergence
Institutional usability determines whether nominal language access becomes effective participation	Consistent organizational and encounter-level evidence	Staffing, scheduling, modality and language-service policy	Moderate	Strong cross-level plausibility but heterogeneous institutional settings
Technology can support bounded language-access tasks without establishing equivalent relational mediation	Emerging evidence	Technology type, language pair and task complexity	Low	Limited and rapidly changing evidence base

The resulting synthesis is represented in **Figure 2**.

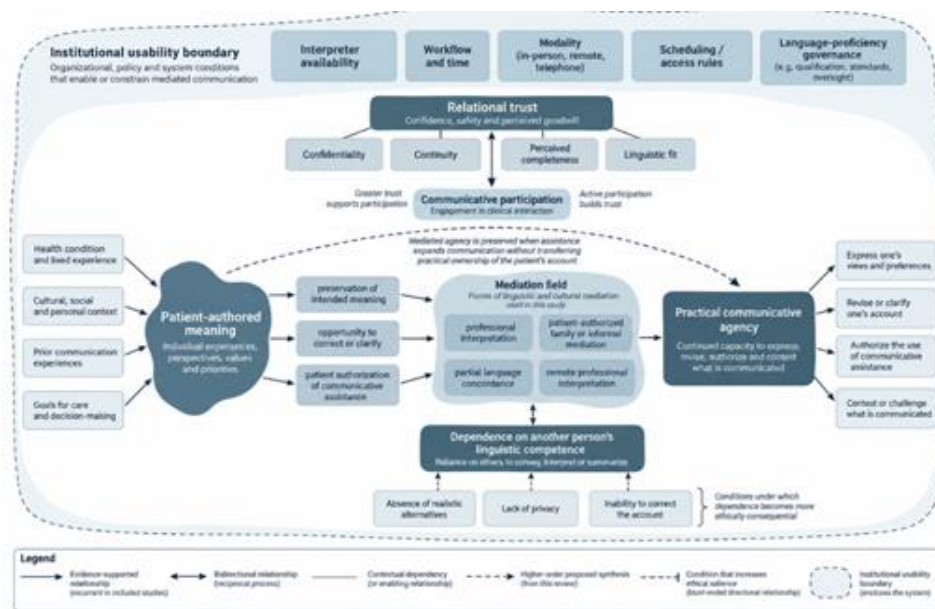


Figure 2. Qualitative synthesis model

This synthesis explains why the literature cannot be reduced to a comparison between interpreter use and non-use. The qualitative nursing review by Seremetkoska and colleagues similarly identifies professional interpretation as valuable while showing that collaboration, role expectations and organizational conditions shape how interpreters function in practice [37]. The present synthesis extends that observation by locating these conditions in relation to patient-authored meaning: communication support is ethically strongest when it increases what patients can express without making another actor the practical owner of their account.

The findings also complicate any assumption that linguistic accuracy alone settles trust. Trust developed through a broader configuration involving perceived completeness, confidentiality, relational continuity, opportunities for correction and confidence that the clinician remained engaged with the patient rather than only with the intermediary. Evidence on relationship-centered communication supports this relational interpretation [38]. Consequently, a technically accurate translation can still be experienced as fragile if the patient cannot verify, qualify or contest what has been communicated.

Institutional conditions are part of this relationship. Interpreter availability, modality, scheduling, staffing and rules governing clinician language proficiency determine whether formal language access becomes practically usable. These conditions help explain why similar forms of mediation can carry different ethical meanings across settings. Reliance on a relative because the patient prefers that relative is analytically different from reliance produced by the absence of a timely professional service. Likewise, direct communication by a genuinely language-proficient clinician differs from improvised partial concordance used because interpretation would substantially delay care.

The review also identifies a technological boundary. Voice-to-voice machine translation can assist selected language-discordant interactions, but current exploratory evidence does not establish equivalence with professional relational mediation [39]. Automated systems may transfer lexical content without reproducing the human functions involved in clarification, contextual interpretation, recognition of uncertainty, and negotiated repair. Their appropriate role should therefore be assessed according to the task being delegated rather than by assuming either replacement or irrelevance.

Several limitations constrain interpretation. The evidence was heterogeneous in population, language pair, clinical setting, actor perspective, and methodological reporting. Patient perspectives were prominent but not universal, and several included studies relied primarily on clinicians, nurses, interpreters or other participants. Concepts such as trust and agency were also defined unevenly; moral agency in particular was usually reconstructed interpretively from evidence about voice, authorization, correction, dependence and participation rather than directly measured. The executed search additionally relied on a bounded scholarly search environment rather than direct institutional exports from every major bibliographic database. The synthesis therefore supports mechanisms and conditions, not universal prevalence estimates.

Practice implications

Language-access practice should evaluate more than whether an interpreter was technically present. Clinicians and services should preserve opportunities for patients to introduce concerns in their own sequence, request clarification, correct interpreted content, indicate discomfort with an interpreter or modality, and remain the primary addressee of clinical reasoning. Interpreter quality therefore includes relational responsiveness alongside linguistic competence.

Healthcare organizations should also distinguish patient-chosen support from structurally forced substitution. Family members may provide valuable emotional, cultural or practical assistance, but institutions should avoid making family availability the default mechanism through which patients gain access to clinical information. Professional interpreting options should remain realistically accessible, while patients should retain meaningful choice about trusted support where clinically appropriate.

Language-service governance should address timeliness, continuity, modality, privacy, interpreter matching and the circumstances in which clinicians communicate directly in a non-primary language. Verified language competence is especially important where technical vocabulary, uncertainty, consent or serious illness increases the consequences of misunderstanding. Remote modalities can expand access, but implementation should monitor whether technical availability is accompanied by privacy, audibility and opportunities for conversational repair.

Automated translation may be useful for bounded tasks. Evidence on machine-translated plain-language patient materials suggests potential value for improving written accessibility under specified conditions [40]. Such tools should be treated as task-specific complements rather than presumptive substitutes for interpretation in encounters where meaning, emotion, uncertainty, consent, or contested preferences require interactive clarification.

Conclusion

Interpreter-mediated care can preserve patient voice and moral agency when linguistic assistance enlarges the patient's practical ability to express, revise, authorize and contest what enters the clinical encounter. The same mediating arrangement can become more ethically fragile when meaning is condensed without repair, confidentiality is uncertain, realistic alternatives are absent, or another person becomes the practical gatekeeper of the patient's account. Trust therefore depends not only on translation accuracy but on whether the communication relationship remains answerable to the patient. Language access is most defensible when dependence on linguistic assistance does not become displacement of patient authority.

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