Language discordance between tuberculosis patients and healthcare providers challenging universal access

To the Editor:

We read with great interest the call for urgent action to ensure access to early diagnosis and care of tuberculosis (TB) among refugees by DARA *et al.* [1]. One of the five recommendations made by the European Respiratory Society and the International Union Against Tuberculosis and Lung Disease is universal access to prevention and treatment services for TB. However, universal access may be impeded by cultural and linguistic barriers [2]. These barriers are most prominent in the initial years following migration and have implications for health, and may affect both access to and quality of care [2–4]. Cultural and linguistic barriers may lead to delays in diagnosis and treatment initiation as well as difficulties in maintaining adherence and effectiveness of contact tracing. Culture and personal experience influences the way in which pain and discomfort are expressed, further complicating mutual understanding between patient and healthcare provider [2].

We asked 71 healthcare providers in 19 TB clinics in England and Scotland about their experience in dealing with patients with limited English proficiency. Clinics were in London (n=10), outside of London in England (n=7), and in Scotland (n=2). Staff included administrative personnel (n=12), social workers (n=6), nurses (n=30), middle grade doctors (n=8) and consultants (n=15); the majority were female (72%). The median (interquartile range) caseload per year per clinic was 80 (50–150) and the median proportion of patients for whom English was not their first language was 40% (29.5–50%). Among these patients a median of 40% (25–52.4%) had limited English proficiency. Languages reported as being most frequently spoken by patients were Hindi (14), Urdu (13), Somali (11), Polish (11), Punjabi (10), Romanian (8), Arabic (8), Bengali (6), Tigrinya (6) and Gujarati (5). 14 clinics had at least one staff member who was bilingual. Telephone interpretation was more frequently used than face-to-face interpretation (table 1). Only half of the staff members felt that interpretation by family members was acceptable (n=39, 55%). Information leaflets were used by almost all staff members (n=65, 92%). The most frequently used were sourced from “TB alert”, a patient support organisation (www.thetruthabouttb.org) (n=50). Other communication tools included online machine translation platforms (Google translate, n=7). Two participants mentioned the app ExplainTB as a means to provide information to patients. The app covers different aspects of TB in 41 chapters and is available in 38 languages (www.explaintb.org/?lang=en).

The majority of staff members felt language barriers resulted in less good quality of care and negatively influenced adherence due to difficulties in understanding instructions. Cultural differences were also felt to be important (table 1).

In addition, staff reported difficulties establishing relationships based on mutual trust with patients with whom they could not communicate in the same language. Lack of communication was felt to adversely affect the information given to and received from patients. Staff were frustrated that information provided to patients often lacked sufficient detail and nuance, and they were confronted with difficulties in verifying the patient’s understanding. There was widespread concern regarding the quality of translation and the inability to assess it. Communication was felt to be particularly challenging when patients were trying to report side-effects, in emergency situations and on the telephone. Consultations were reported to be more time-consuming, adding pressure to TB services.

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Language barriers are a significant problem for patients with tuberculosis in England and Scotland
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TABLE 1 Use of interpretation services and healthcare providers' perceptions (n=71)

Use of interpreters when seeing patients with limited language proficiency	
Ever using face-to-face interpreters	58 (82)
Less than monthly	36 (51)
Ever using telephone interpreters	65 (91)
At least weekly	54 (76)
Healthcare providers' perceptions	
"It is acceptable to make family members translate"	39 (55)
"Language barriers impact on quality of care"	45 (63)
"Language barrier effect adherence"	44 (62)
"Cultural differences are sometimes more important than language barriers"	46 (65)

Data are presented as n (%).

Over the past 2 years European countries have experienced an increased influx of migrants from war and conflict areas with high TB incidence. In most European countries migrants are screened for active TB on arrival [5]. However, even in displaced persons who are settled in a foreign host country, language barriers impair access to diagnostics and continuous management of TB. Professional interpreters are often used to try to overcome language barriers, as shown in this survey, as well as by other studies [2, 4, 6]. However, they may not be readily available, especially in emergency situations, and limited resources may prohibit frequent use. Ensuring privacy and confidentiality when using professional and non-professional interpreters such as family and friends is challenging [2, 7]. Other issues which may arise when using interpreters during a consultation include potential misinformation due to addition, omission, substitution and condensation. Leaflets, films, and apps may partly substitute for the inability to provide detailed information, but cannot mitigate the impact of language and cultural barriers on the patient-provider relationship.

Healthcare staff and TB control programmes need to be aware of these limitations when dealing with patients with limited language proficiency to overcome health inequalities and achieve universal access.

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