Language discordance between TB patients and health care providers challenging universal access

Dorothy Nakiwala[1], Lusha Kellgren[2], Christian Herzmann[3], Ioana D. Olaru[3], Mike Brown[2,4], Rashida Ferrand[1], Palwasha Khan[1], Katharina Kranzer[1,5]

1 London School of Hygiene and Tropical Medicine, London, United Kingdom

2 North Central London South Hub TB Clinic, Whittington Health, London, United Kingdom

3 Center for Clinical Studies, Research Center Borstel, Borstel, Germany

4 Hospital for Tropical Diseases, University College London Hospital, London, United Kingdom

5 National Mycobacterium Reference Laboratory, Research Center Borstel, Borstel, Germany

*Correspondence:

Katharina Kranzer, Faculty of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine, Keppel Street, London, WC1E 7HT, UK.

E-mail: katharina.kranzer@lshtm.ac.uk

Word count: 726

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 by the European Respiratory Society and the International Union Against TB 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 on 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 health care provider.[2]

We asked 71 health care providers in nineteen 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 caseload per year per clinic was 80 (IQR 50-150) and the median proportion of patients for whom English was not their first language was 40% (IQR 29.5-50). Among these patients a median of 40% (IQR 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). Fourteen 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, 52%). 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 (http://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 (http://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.

Over the past two 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 patient-provider relationship.

Health care 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.

Table 1: Use of interpretation services and health care providers' perceptions

	N=71 (%)
Use of interpreters when seeing patients with limited language proficiency	
Ever using face-to-face interpreters	58 (85%)
• Less than monthly	36 (62%)
Ever using telephone interpreters	65 (90%)
• At least weekly	54 (86%)
Health care providers' perceptions	
"It is acceptable to make family members translate"	39 (52%)
"Language barriers impact on quality of care"	45 (63%)
"Language barrier effect adherence"	44 (63%)
"Cultural differences are sometimes more important than language barriers "	46 (66%)

References

1. Dara M, Solovic I, Sotgiu G, et al. Call for urgent actions to ensure access to early diagnosis and care of tuberculosis among refugees: Statement of the European Respiratory Society and the European Region of the International Union Against Tuberculosis and Lung Disease. *The European respiratory journal* 2016; **47**(5): 1345-7.
2. Bischoff A, Hudelson P. Access to healthcare interpreter services: where are we and where do we need to go? *International journal of environmental research and public health* 2010; **7**(7): 2838-44.
3. Gardam M, Verma G, Campbell A, Wang J, Khan K. Impact of the patient-provider relationship on the survival of foreign born outpatients with tuberculosis. *Journal of immigrant and minority health* 2009; **11**(6): 437-45.
4. Hudelson P, Vilpert S. Overcoming language barriers with foreign-language speaking patients: a survey to investigate intra-hospital variation in attitudes and practices. *BMC health services research* 2009; **9**: 187.
5. Dara M, Solovic I, Sotgiu G, et al. Tuberculosis care among refugees arriving in Europe: a ERS/WHO Europe Region survey of current practices. *The European respiratory journal* 2016; **48**(3): 808-17.
6. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res* 2007; **42**(2): 727-54.
7. Kale E, Syed HR. Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. *Patient Educ Couns* 2010; **81**(2): 187-91.