CULTURAL, SOCIAL & LINGUISTIC BARRIERS

Can they be overcome?

Cultural, social and linguistic barriers are a great challenge for healthcare providers. In order to overcome these barriers, clinicians must rethink their daily clinical work. The data compared in this article show that immigrants in Europe differ from natives but also from their countrymen at home. The investigation of this population should help us to provide better healthcare.

Marina Sleptsova
Clinical Psychologist and Master in Cognitive-behavioural Psychotherapy
University Hospital Basel
Switzerland

Increasing migration worldwide leads to formation of multi-ethnic societies. In 2006, there were about 200 million immigrants worldwide. Ethnic and cultural diversity presents a great challenge for all healthcare providers. Problems arising through this diversity are wide-ranging and require rethinking of already existing healthcare approaches and structures.

Talking about racial and ethnic differences highlights an important question: terminology of ethnic categories is often inconsistent and problematic. Use of such basic terms like 'race', 'ethnicity' and 'minority' is almost always undifferentiated. The diversity of minority groups less homogenous is not usually perceived by an observer who does not belong to this group. Usual terminology also does not take into account the degree of acculturation to the country of immigration.

Racial disparities in health and health treatment

Racial disparities in health have been well-described in current literature. Data shows that members of minority groups suffer disproportionately more cardiovascular disease, diabetes, asthma, and cancer. Musculoskeletal pain is more prevalent among immigrants in Europe than among native Europeans. Mood disorders among immigrants to Europe have also been reported to be more prevalent than among native Europeans, but not all studies confirmed these findings.

Racial differences among migrants result in migrants receiving unequal treatment. Most studies find that various ethnic groups are not given equal healthcare. This inequality of healthcare for various ethnic groups was observed for instance in pain treatment for all types of pain (i.e. acute, cancer, chronic non-malignant) and in all settings (i.e. postoperative, emergency room).

Communication between doctor and patient is often negatively affected by these cultural differences. In medical consultation, both migrant patients and their providers interact differently than natives and their clinicians do. To reduce racial and cultural disparity in care, the authors recommend that healthcare providers and organisations employ a culturally sensitive approach.

Culturally competent approach

The quality of the relationship between the clinician and the patient is crucial for diagnosis, treatment and healing. Patient-centred encounters increase patient satisfaction and improve medical outcomes. Similarly, cultural competency in treatment of migrant patients is recognised as an essential factor for the quality of

What characterises migrants in Europe?

In their host country, migrants differ from natives. Migrants are disrooted in many ways from their country of origin. At the onset of their migration, there are two possibilities. Either migrant who voluntarily leave their home country are more courageous and healthier than the average population in their country, or migrants forced to leave their country represent a sociologically handicapped section of the population. Healthy migrants to Europe consider their quality of life to be higher than that of their healthy fellow countrymen who remain home . However, if Turkish migrant patients in Switzerland get ill, they assess their quality-of-life a great deal worse than their country-men in Turkey do (See Table 1).

Scales, SF 36	Sleptsova *et al.*, 2008 114 Turkish migrant chronic pain patients	Tuzun *et al.*, 2004 99 Turkish chronic pain patients in Turkey
	Mean, SD	Mean; SD
Physical Functioning	39.35; 21.6	67.27; 18.59
Role-Physical	6.36; 20.7	39.09; 37.26
Bodily Pain	18.67; 16.5	33.18; 17.73
General Health	21.85; 14.9	36.42; 22.26
Social Functioning	37.06; 23.8	59.09; 28.17
Role-Emotional	11.4; 27.9	44.43; 43.83
Mental Health	32.04; 18.5	54.91; 21.85
Vitality	22.76; 17.8	39.32; 19.83

Table 1. Comparison of Scales SF36 of Turkish migrant patients in Switzerland and Turkish patients in Turkey. Iranian and Turkish immigrants in Sweden report poorer health and poorer health-related quality-of-life than native Swedes do, unless socio-economic status, Swedish language proficiency, and racial discrimination are also considered.

Likewise, Turkish chronic pain patients in Switzerland report lower quality-of-life than German native chronic pain patients do (See Table 2).

Scales, SF 36	Sleptsova *et al.*, 2008 114 Turkish migrant chronic pain patients	Huge *et al.*, 2006 83 German native chronic pain patients
	Mean, SD	Mean; SD
Physical Functioning	39.35; 21.6	50; 20.4
Role-Physical	6.36; 20.7	15.9; 32.3
Bodily Pain	18.67; 16.5	27.2; 13.5
General Health	21.85; 14.9	46.9; 18.3
Social Functioning	37.06; 23.8	56.3; 28.3
Role-Emotional	11.4; 27.9	66.7; 43.6
Mental Health	32.04; 18.5	59.1; 22.7
Vitality	22.76; 17.8	39.6; 22.4

Table 2. Comparison of Scales SF36 of Turkish migrant patients in Switzerland and German patients in Germany.

Migrant workers coming from outside the European Union to Western Europe tend to be more socio-economically disadvantaged. They are less educated than natives. Migrants work in low-paid and more hazardous jobs. The following comparison illustrates that Turkish migrant chronic pain patients in Switzerland have less formal education than native chronic pain patients in Germany.

Characteristics	Basler *et al.*, Germany	Sleptsova *et al.*, Switzerland
Number of participants	220	116
Education duration		
No school education, %	0	23.3
First 5 school years, %	0	54.3
Further 3 school years, %	43.9	15.5
University, %	56.1	6.9

Table 3. Comparison of formal education of Turkish migrant patients in Switzerland to that of native patients in Germany.

healthcare. Thus, patient-centred communication should contain the specification of cultural competency.

Many authors present 'cultural competency' as an integrative model of the healthcare system at both institutional and professional levels. The institutional level of such a culturally competent healthcare system requires primarily that both interpreter services and culturally and linguistically appropriate health education materials are available. Training programmes for healthcare providers to develop their cultural competency are necessary at the professional level of such a healthcare system. Such training programmes improve knowledge, attitudes, and skills of health professionals, which influence patient satisfaction positively.

The perspective of the patient to culturally sensitive healthcare has also been investigated. Along with universal themes like individualised treatment, effective communication and professional competency, results revealed that patients wish a culturally specific patient education and culturally sensitive staff.

Culture, culturally sensitive and culturally competent

An increasing quantity of current literature has begun to reflect on terminology. Fundamental terms such as 'culture', 'culturally sensitive' and 'culturally competent' in medical context begin to be used by clinicians who are confronted everyday by migrant patients. The need to articulate clear definitions of these terms and find consensus has been slowly recognised. One thing is clear: Culture is a dynamic concept. Moreover, culture varies within an ethnic group and is in change. Most authors emphasise that clinicians must become aware of and also respect differences in cultures. Clinicians should recognise unique cultural and religious beliefs, ethnic values, and traditional practices—all of which can be in transformation—within any ethnic group. Cultural sensitiveness and competency requires that the clinician reflect on his or her own cultural system. Self-reflection is necessary to develop awareness of one's own attitude toward persons of different ethnic or cultural groups.

> "Several studies establish that professional interpreters have a positive impact on clinical care. Lack of linguistic comprehension decreases patient satisfaction."

Linguistic barriers in healthcare

Although current studies show that language is not the only influence on the quality of clinical communication, nevertheless language proficiency does play a very important role in medical encounter. Several studies establish that professional interpreters have a positive impact on clinical care. Lack of linguistic comprehension decreases patient satisfaction. Whereas concordance of language between the clinician and his or her patient does reduce emergency visits and their costs, in general, such enhanced interpreter service intervention does not significantly change hospital costs.

Growing use of the interpreter presents new problems to researchers and clinicians. The role of the interpreter in the clinician-patient consultation has not been clearly ascertained. The so-called transmission model of communication introduced by Shannon and Weaver requires precise and complete translation. In clinical reality, however, this theoretical model does not suffice.

The role of the interpreter in healthcare settings has been discussed, but consensus is yet to be achieved. One of these roles is that of the so-called 'cultural broker'. Can culture really be translated?

In any case, the quality of clinical consultation depends on mutual agreement by all participants about the interpreter's role. However, innovative strategies of medical translation, for instance Remote Simultaneous Medical Interpreting (RSMI) have been introduced and tested in the clinical practice. This strategy of translation removes the person interpreting from the presence of the patient. Patients believe their privacy is better protected and feel more satisfied than in consultations with usual interpreting.

Conclusion

In healthcare systems today, the problems of cultural diversity seem to be perceived and taken seriously than ever before. Nevertheless, far too little research has been made on this topic. A natural tendency of most health researchers is to take on the cultural perspective of the majority ethnic group to which they belong, at the expense of the perspective of minority ethnic groups. Development of culturally competent researchers is in any case needed. Such culturally competent researchers could initiate both needed investigations as well as culturally competent practice. Because there is so little research about the effectiveness of culturally competent healthcare systems, it could not even be determined.

If ethnic and racial disparity and its ensuing consequences are to be reduced or even eliminated, healthcare systems must overcome cultural, linguistic and social barriers. ■

References are available at http://www.asianhhm.com/magazine

AUTHOR

Marina Sleptsova Schwander is a clinical psychologist and psychotherapist, was born in the Russian Republic of Sakha. She studied psychology in St. Petersburg. She earned her MA in cognitive behavioural therapy at the University Basel, Switzerland. Since 2000, she has been working at the Psychosomatic Department of the University Basel Hospital. She is married and is mother of two children.