Migrants and health: a cultural dilemma

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ABSTRACT – Culture profoundly affects what those who come to the UK as migrants believe about disease and thus how they behave during illness. Their beliefs may be very different from the beliefs of healthcare professionals and so there can be difficulties in understanding and barriers which inhibit effective clinical management. The behaviour of healthcare professionals towards those of a different race can lead to feelings of discrimination and lack of sympathy, so that a gulf can be allowed to develop. This gulf can be bridged if simple measures are adopted: training in communication, culturally sensitive health-promotion programmes, specific programmes relevant for those of defined ethnic groups and, as a basic means to increase confidence and trust, elementary skills in the language of the migrants.

KEY WORDS: beliefs, culture, communication, discrimination, epilepsy, health-promotion, migrant, obesity, race, stigma

In the press of a crowded clinic, it can be easy to forget that the recent migrants to the UK who are waiting to be seen and treated have a wholly different understanding of disease from those to whom they have been sent and from whom they expect treatment. They may even have a muted distrust of the confident foreigner who, screened by a chilly white coat, is waiting to see them.

It is not only the recent migrant who can feel lonely, isolated and misunderstood. Anyone who has grown up in a different culture will have absorbed distinctive traditions, ideas, beliefs and hopes from childhood which will inevitably influence how they respond to illness and to the demands of a system of healthcare. They come to the clinic not only with the burden of their illness but also with the cultural fabric of their lives. Sadly, their beliefs, so important as they struggle with the puzzle of sickness in a strange land, may be discounted and their hopes for understanding may be dashed as they are put through a meticulous history and examination. They are apprehensive. The clinical method may be unfamiliar and the subsequent logical explanation which they receive so remote that their cultural isolation becomes even more pronounced. But some treatment is prescribed and they receive tablets which, as is carefully explained, will help greatly. But this is bewildering: why should it be necessary to take tablets every day while at home it was one dose, one injection or one application? That traditional treatment seemed to be effective… To add to their confusion they are asked to return to see the same distant doctor: what sort of healers are these who so doubt the efficacy of their treatment that they want to see them again?

While this may be an extreme example, it touches on some of the essential problems of clinical practice across cultures. Illness can frighten; fear is sharper in an unfamiliar place which is linguistically and culturally alien. This short paper considers some of the problems. We write as people with experience of cultures and countries different from those in which we grew up and were trained in medicine.

The perception of time

Migrants to the UK may well think that, in our culture, time is regarded as a ruthless tyrant who controls us absolutely. Bound as we are by the clock, we fail to realise that other cultures are not similarly oppressed! When we excuse ourselves with expressions such as 'I am afraid that I *must* go', or 'I am sorry that I am *late*' we may well be giving a stranger a view of an attitude to time which is unknown. Is it therefore surprising that cultures clash at the clock? There are profoundly different attitudes to time. Life lived in the present and an orientation to the present distinguished African Americans from white Americans, who were far more future oriented,[1] and could thus more easily grasp that they could be more susceptible to the consequences of hypertension and so believed more in the benefits of their prescribed

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Key Points

- **A recent migrant to the UK may feel culturally isolated during illness**
- **Healthcare professionals may not understand that the culture of those of a different race determines how they behave during illness**
- **Perceptions of health and disease differ profoundly between different ethnic groups**
- **Culturally sensitive health promotion for ethnic minorities, given by healthcare professionals trained in communication, would bring substantial benefits**

medication. When that 'difficult' migrant patient stops taking drugs for hypertension, is it because he takes little account of the future? Is it because he grew up in a society where infant and under-fives mortality was pathetically high so that survival now was paramount and future care seems irrelevant?

The perception of causes of illness

While it may be helpful to dissect out one characteristic from a system of beliefs, it is thoroughly artificial. Such beliefs constitute a whole fabric in which one thread of belief is intimately woven with another and with the practices that result from it. There is a danger that health educators at clinics and in the community may be seen to be giving messages that are part of an entirely different and incompatible fabric.

Obesity

In parts of West Africa, obesity is perceived as a sign of good health and as evidence of good living, while complications associated with it are frequently ascribed to forces beyond the obese person's control. If this is how I have always regarded my body, the obese patient ponders, why should this nurse or doctor seek to alter what I believe? Why should my beliefs be exchanged for their beliefs?

Stroke

In the same region of West Africa, stroke is believed to result from the strike of some evil forces under the influence of a known or imagined enemy, or from the malevolent activity of an aggrieved ancestor.

Epilepsy

In many societies, epilepsy breeds a stigma which is very difficult to break and this is compounded by its treatment. The sudden and dramatic changes during a seizure are attributed, irrespective of ethnic origin, to evil spirits or more specifically to the *djinns* (evil spirits) as in Mauretanian culture.[2] The widespread belief that epilepsy is contagious, so that it is dangerous to touch the individual with a seizure, can make immediate and subsequent care a real problem. Even in the more prosperous society of Hong Kong, a study of the perceptions held by parents about their children with epilepsy showed that fewer than 50% were aware that seizures were caused by abnormal brain discharges.[3]

Many examples could be given about the cultural understanding of the causes of disease and the pages of Pub Med are full of them. These may be anthropologically fascinating, but that is irrelevant in a busy clinic. The critical issue is to define the effects of beliefs upon the patient's attitude towards treatment and continuing care. It may, for example, be very difficult for advice on amputation to be accepted, because it is seen to be a deforming treatment: the consequences of leaving the diseased limb are not even considered.

The perceived barriers to care

It is all too easy for the migrant to feel that the society and the system are prejudiced against him and, sadly, the unfortunate experience of some can fuel this feeling. A study of barriers hindering Chinese people with mental health needs in England from obtaining appropriate help from the NHS identified, among other things, that they perceived their symptoms as somatic rather than psychiatric in origin.[4] Among inner city 12-year-olds from four ethnic groups in London, ethnicity alone was insufficient and inadequate to explain variations in health behaviour.[5] Instead a complex mix of personal, cultural and social factors including ethnicity were thought to shape the behaviour and attitudes of these young people. Gilvarry *et al* studied life events, ethnicity and perception of discrimination in patients with severe mental illness in the UK. They tested the hypothesis that black and ethnic minority (B&EM) patients experienced more negative life events than their white British (WB) counterparts, but did not find any significant difference in life events between the two study groups.[6] However, there was a significant difference in their perception of these events, in that the B&EM group often attributed them to racism, unlike the WB group. The authors thought it reasonable to suppose that B&EM patients may be disinclined to utilise services which they perceived to be prejudiced against them.

The attitudes of healthcare professionals

While differences in cultural perceptions of health and illness may be obvious among patients, significant differences also exist among healthcare professionals, so that the ways in which they perceive, interpret and manage illnesses in different ethnocultural groups differ widely. The perceptions of problematic behaviours and the suggested management of those behaviours by six minority groups (Chinese-Americans, African-Americans, Filipino-Americans, Native-Americans, Mexican-Americans, Appalachians) among mental health professionals from three American states revealed significant differences between these different mental health professional groups, both in the labels placed on problematic behaviours and in their suggested management.[7]

Health professionals may, consciously or unconsciously, discriminate in the treatments they prescribe: the records of more than 169,000 Medicare patients in the US, treated for heart attack over two years, showed that even inexpensive, effective treatments, like aspirin, were less likely to be given to African-Americans, women and poor patients than to others.[8] The authors of the study concluded that race influenced treatment recommendations for individual patients, and that poorer individuals seemed to experience differences in care, even when treatment was covered by Medicare. They suggested that some doctors might think that women and people of certain backgrounds would not react well to certain heart prevention therapies, and thus might not recommend them. But these differences might be explained by the way in which the patients described their symptoms, and how doctors interpreted them.

Patients themselves may clearly perceive differences in behaviour towards them because of their racial origin. An example could be differences in admission practices: for example, Singh *et al* found that Black-Caribbean patients in the UK were more often admitted compulsorily to psychiatric wards than patients from other ethnic groups.[9] Young Black-Caribbeans were perceived to be liable to violent behaviour, and thus were significantly more likely to receive a diagnosis of psychosis, and to be compulsorily detained.

Is it therefore surprising that some dissatisfied sickle cell disease patients from East London, who saw themselves as vulnerable to a stereotyped perception by some healthcare professionals, should have described the healthcare system as 'unsatisfactory, inappropriate and a total waste of time and public money'?

Such expressions are to be expected when ethnic and cultural factors are permitted, consciously or not, to determine the course of any part of healthcare. Patients expect healthcare professionals to help them in managing their illnesses from their personal perspectives. This can be very difficult for both patient and professional when neither can get inside the other's mind and understanding. We have heard words such as uncaring, unsympathetic, arrogant, playing God, unwilling or 'unable to listen to any word I said'.

Descriptive terms such as these are not necessarily correct in the context and could deeply upset a caring professional person who has been trying to do their best, but they often reflect patients' collective perception of healthcare professionals and the services they provide. So, what to do?

Recommendations

We are well aware that much is already being done to bridge the gulf which exists between migrants and healthcare professionals. Many people are trying very hard and are successful, but, as we have tried to emphasise, cultural differences run very deep. We have therefore set out simple suggestions which offer a realistic chance of making a difference. The benefits could be substantial for patients, professionals and for healthcare. Our recommendations would cost money but the benefits would be worth every penny spent.

1 *Training in communication* across cultures is essential, if healthcare professionals are to be enabled to engage and communicate with ethno-cultural minority patients in the most sensitive and appropriately professional manner.

2 *Culturally sensitive health-promotion programmes* for different ethno-social groups should be organised in partnership with relevant agencies and community leaders. Communities should be encouraged and enabled to assume ownership of the programmes, with relevant healthcare agencies maintaining monitoring roles.

3 *Sustained health screening* and disease-awareness programmes should be targeted at different ethnic minority groups, employing appropriate, relevant and socio-culturally acceptable methods, including appropriate language.

4 Where *language* is a problem, healthcare workers could learn a few basic greetings: not only would the patient take back to the community the good news that the professionals were interested in learning some words of their language, but individual patients would feel so much more valued and so much more part of a forbidding healthcare system if they were greeted in this way.

Conclusion

For the gulf to be bridged, both healthcare professionals and members of ethnic minority groups need to recognise that greater patience and understanding are required. For both the providers and the receivers of healthcare, basic common-sense training should be given.

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