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# The health of migrants: the doctor-patient relationship

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Dear Editor,

The Consolidated Act on Immigration (Legislative Decree No. 286 of 1998) states: "Access to healthcare facilities by foreigners who are not in compliance with residence regulations shall not result in any type of report to the authorities, except in cases where reporting is mandatory, under the same conditions as for Italian citizens".

This law grants immigrants, including those without regular status, the right to receive assistance not only in emergencies but also for essential care. This article examines the additional critical issues present in the doctor-migrant patient relationship.

The statistical data presented in the previous article illustrate the scale of the problem.[1]

By examining preconceptions, analyzing critical issues, and discussing current projects and proposals, we aim to provide an overview for professionals involved in migrant health.

The doctor-patient relationship is always complex and, as in any expert-novice dynamic, it initially involves a significant disparity between the role and knowledge of the doctor and those of the patient. In the doctor-migrant patient relationship, this is further complicated by the intrinsic asymmetry between native and non-native interactions.

In fact, cultural differences often make interactions more complicated and are hindered by numerous preconceptions on both sides. Among these, the most common are the "Salgari Syndrome" and the "General Hospital Syndrome".

The "Salgari Syndrome" refers to viewing others as carriers of mostly strange and fantastical tropical diseases. Salgari, in fact, imagined and described exotic worlds he had never visited.[2] However, the epidemiological reality shows that immigrants, selected by the difficulties of the entire migration process, tend to be healthier – not only compared to their compatriots back home, but also to citizens of their destination countries (the healthy migrant phenomenon). This is because, before departure, a selection process occurs to choose the son or daughter who can provide economic benefits to the family. The workforce that determines the success of the migration project is linked to youth and physical health. However, once in Italy, migrants are susceptible to the same diseases as the native population.

The "General Hospital Syndrome", on the other hand, describes how patients are influenced by stereotypes of high-tech Western healthcare systems, which are seen as miraculous and extremely efficient. Many believe their health problems will be resolved quickly and positively. As a result, they are unwilling to undergo repeated visits and do not accept mistakes or unsuccessful treatments. Additionally, the provisions of the Consolidated Act are not enough to dispel the fears of migrants in irregular legal situations that they might be reported by healthcare personnel.

From a psychological perspective, migrants are people who face issues related to both abandonment and grief, and the new reality can profoundly impact multiple aspects of their identity. Added to this are uprooting, adaptation challenges, environmental uncertainties, low-skilled work, temptations to engage in risky behaviors, instability in the society into which they are integrated, and disillusionment due to inconsistencies between reality and the long-cherished dream of migration. The burden of all this is increased by differing views of suffering and death. The expression of pain also varies greatly; it may be exaggerated or, at times, concealed. In this context, a lack of awareness of cultural codes can lead to different interpretations of illness and its meaning, compromising both diagnosis and treatment.

In contemporary Western societies affected by immigration, healthcare institutions are among the contexts most characterized by interlinguistic and intercultural contacts. Since human communication is not limited to words alone, but also involves relational aspects, it is important for doctors treating migrants to consider perspectives beyond their own, adopt a convergent and unbiased attitude, and be willing to listen and negotiate to avoid misunderstandings and conflicts.

In this regard, the study by the Working Group on Communication with Foreign Patients, conducted by the Venice Medical Association,[3] is noteworthy. This study, carried out from February to November 2019, used a questionnaire administered through face-to-face interviews and shared on social media and WhatsApp. A total of 829 doctors and 43 migrants responded: migrants showed little

interest in indirect administration, preferring personal contact through their networks of acquaintances (direct or indirect). The results show that:

- Almost all doctors interviewed are predominantly Italian speakers, with only insignificant percentages having knowledge of other languages such as English, German, French, Croatian, and Romanian.
- The most common native languages among immigrants are Arabic (23.3%), French (25.6%), Spanish (14%), and Serbo-Croatian (11.6%), followed by smaller percentages of Romanian, English, Tagalog, Ukrainian, and Georgian.
- Migrant patients demonstrate much greater diversity and prevalence of multilingualism than physicians (93% report speaking other languages, with the most common being Italian, English, French, and Spanish, followed by German, Arabic, Russian, and Moldovan).
- Greater and more predictable challenges relate to written communication. The study also reveals that migrant patients' understanding of both prescriptions and patient information leaflets is extremely poor (34.4%).

The study also found that 41.5% of participating doctors reported difficulty treating foreign patients, attributing these challenges almost exclusively to language barriers, without recognizing other critical issues.

Regarding language, we must highlight several types of difficulties:

- Prelinguistic difficulties refer to barriers in communication caused by the inability of language to convey a basic, "indicative" meaning (i.e., without emotional nuances or subjective interpretations). This inability to express inner distress is universal but is greatly magnified for immigrants, who, when faced with a doctor, may find themselves unable to connect or find ways to discuss their inner feelings.[4]
- Linguistic difficulties can result in double errors: on the part of the migrant when translating from their ethnic language to their official language, and on the part of the doctor when translating from Italian to the patient's official language.
- Semiotic or metalinguistic difficulties arise from the arbitrariness of symbolic values.[5] For example, diseases like cancer or AIDS may not carry the same social and cultural weight for migrants as in the host culture.

Although technology-based language translation tools can be helpful, they are not particularly successful in doctor-migrant communication. Personal relationships remain more effective, especially with the use of cultural mediators who are proficient in different languages. This role requires not only language translation skills and the ability to act as an intermediary between the individual's needs and their cultural background, but also a solid understanding of the Italian welfare system and social and health services. In doctor-migrant encounters, the mediator's task is to facilitate the expression and communication of the many conflicting emotions experienced by migrants, such as hope and rejection, desire and fear, anger and frustration.

Another aspect that could improve doctor-patient interactions is enhancing patients' Italian language skills. This is considered crucial for effective communication. Therefore, establishing Italian courses for the migrant population is recommended to increase the level of competence needed to manage and evaluate information.

For medical and paramedical staff, cultural training courses should be prioritized over language courses.

During medical examinations, a widespread cultural difference must be considered: male patients are often reluctant to be examined by female doctors, just as female patients may not want to undress or be examined by male doctors. As a result, the medical examination becomes a highly delicate moment requiring understanding, attention, and patience. A genital examination should be conducted even if there is resistance from the female patient or her male companion, as infections in the genital and perianal areas are common.

Using informal language with strangers is often justified by the need to simplify communication or make the patient more comfortable, but it is not enough to improve the doctor-patient relationship.

When taking a patient's medical history, close attention must be paid to epidemiology as well as the ethnic and religious background of the country of origin.
The new Action Plan for the Health of Refugees and Migrants in the WHO European Region for 2023-2030 seeks to support countries so that health for all—including refugees and migrants—becomes a reality. The plan aims to "articulate a common vision for health and migration in the Region and outline the strategic actions needed to realize the potential of migration to contribute to resourceful and resilient populations, and an economy of well-being for all".[6,7]

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