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Communication with Health Care Services-Experiences of Kurdish Refugees in Scandinavian Countries

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Abstract

Background: According to recent statistics, the number of people who had fled their own home by 2015 was 59.5 million. In this context, the number of people who need a third person as a language link in communication with health care services has increased dramatically. This issue has led to a major challenge to healthcare providers to fulfill immigrants' needs in communication with health care services in resettlement countries.
Aim: To study Kurdish refugees' experiences concerning communication with health care services in resettlement countries.
Methods: Focus group interviews carried out with five groups of Kurdish refugees (N=21). The group interviews were transcribed, interpreted, analyzed and the text was categorized according to the content analysis method.
Results: A number of difficulties regarding communication with health care services with the use of an interpreter, as well as with immigrants' independent communication, were highlighted by the present study. Participants' dissatisfaction with interpreters, and their competence in communication through an interpreter were reasons why some of them avoided using an interpreter although their language knowledge was limited. The other group finally had to use interpreters following their exaggeration of their language ability, meanwhile the third group waited until their language skills were good enough for independent communication.
Conclusion: A number of difficulties concerning the Kurdish refugees' communication with health care services in Scandinavian countries were revealed by the present study. Interpreters' linguistic incompetence, their relatives' impartially and lack of language knowledge in communication through interpreters were problems mentioned by participants. Dissatisfaction with professional interpreters' competence, exaggeration of their own language ability by some of the participants and sufficient language knowledge were motives for Kurdish refugees' tendency to make independent communication with health care services.

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Introduction

According to the recent statistics recorded in June 2015, the number of people who had fled their own homes reached 59.5 million, whereby in the past year more people have been displaced than at any time since UNHCR immigrant records began [1]. Due to the dramatic events in their previous life and traumatic events during the migration process, immigrants need to visit healthcare centers more often than the native population [2]. In this context, strong language ability and secure communication for immigrant patients has a significant impact on health outcome [3]. We have little knowledge about immigrants' physical and psychological health, as well as the difficulties they experience in communication with the healthcare services in resettlement countries [4, 5]. According to previous studies, insufficient clinical communication between an immigrant patient with limited language ability and healthcare professionals can lead to communication misunderstandings, the risk of misdiagnosis and poor compliance with treatment [6].

Healthcare Communication

In order to reduce cross-cultural communication misunderstandings in providing healthcare to immigrant patients, adaptation of the health care systems to this cultural diversity is critical. In spite of the efforts of healthcare professionals to improve the quality of healthcare for every patient over the last decades, there are some further factors that create difficulties in providing an equally high quality of health care to ethnic minorities, in comparison with the native-language-speaking patients [7-9]. The importance of this issue is being discussed in countries such as Canada, Australia and the United States of America, that have high rates of immigrant populations [10]. Providing appropriate healthcare to all inhabitants at satisfactory level requires a framework that makes it possible for all patients, with diversities in race, ethnicity, or cultural backgrounds to have opportunities to communicate with healthcare providers at such a level that results in mutual understanding [11]. Furthermore, in providing an adequate healthcare service to immigrant patients, it is important for primary healthcare providers to understand the immigrants' experiences of migration process factors and differences in immigrant groups' reactions to these experiences [2, 12]. Based on previous studies, not only their limited language skills, but also the immigrants' levels of healthcare literacy have an important role in the provision of healthcare to immigrant patients. In this context, the role of interpreters includes both communication assistance and acting as practical and informative guides regarding routines in the healthcare system [13, 14]. Use of relatives or friends and health care providers as interpreters may resolve the communication problem in many emergency cases,

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but it should never replace the use of professional interpreters [15]. In order to improve health outcomes in communication with health care services, professional, qualified interpreters are needed [16, 17]. The purpose of this study was to identify immigrants' difficulties in communication with the healthcare system in resettlement countries.

Aims

To study Kurdish refugees' experiences concerning communication with health care services in resettlement countries.

Methods

Setting and participants

Through Kurdish cultural centers in Sweden, Denmark and Norway, 32 persons (15 from Sweden, 9 from Denmark and 8 from Norway) were asked to participate in the group discussions. 25 of them agreed to participate. Finally 21 persons, eight women aged 39-52 (mean 48.5) years and 13 men aged 46-64 (mean 57), agreed to participate (table 1). They had been in Scandinavia between 10 and 28 years. The number of participants in Sweden was 10 persons (two groups), in Denmark 8 persons (two groups), and in Norway 5 persons (one group). Four of the participants declined participation for practical reasons.

Data collection

In total, five focus group discussions were carried out with the participants, led by one of the authors (NF), between September 2014 and April 2015. All group discussion were conducted in the participants' mother tongue (Kurdish) and translated into English by one of the authors (NF). Group discussions lasted between 55-75 minutes, with a total of 340 minutes. Participant selection was according to availability, within a reasonable geographical reach. We preferred invited immigrants who had been in Scandinavian countries for at least 10 years, because we wanted to know about the immigrants' experiences regarding communication with health care, both through an interpreter and in independent communication. On the other hand, immigrants who had learnt the language of their resettlement countries could better describe the difficulties they had in communication with health care services and indicate the sources of these problems. Information about the purpose of the study was sent to all participants through Kurdish cultural centers before the group discussions.

Data analysis

As the main aim of the present study was to learn about Kurdish refugees' experiences of communication with health care services, a qualitative analysis method was needed to interpret the collected data. In this context, we found the content analysis method [18] to be an appropriate method for analysis and interpretation of the interviews. The advantage of this method for analysis in the present study is that, apart from analysis of the manifest text, the method allows interpretation of latent content in the material, that is, analysis of what the text talks about. This issue is very important for analysis in this study because the study contains many culturally related concepts that need to be interpreted rather than translated. In accordance with the content analysis method [18], the analysis of the group discussions was conducted in six steps (Table 2): identification of words, sentences and paragraphs that have the same essential meaning built of condensed meaning units related to each other, labeling condensed texts with a code and bringing related codes together, in order to find subcategories, categories and themes. The last step is presentation of the results with direct quotations from the interviews.

Nr	Age (Years)	Occupation in Scandinavian	Residency in Scandinavian (No. of years)
1	48	State employee	18
1	64	Jobless	17
2	56	Taxi driver	21
3	46	State employee	11
4	50	Taxi driver	21
5	55	Nurse Assistant	26
6	51	Teacher in mother tongue	20
7	49	Nurse assistant	14
8	39	Jobless	10
9	60	Taxi driver	28
10	49	State employee	16
11	57	State employee	22
12	52	Jobless	23
13	50	State employee	17
14	58	Taxi driver	20
15	46	Engeneer	10
16	49	Nurse Assistant	16
17	48	Jobless	12
18	50	State employee	21
19	46	Worker	20
20	58	Worker	20
21	48	Jobless	11

Table 1.Background data of the study group (n=21).

Ethical Approval

According to the Swedish law, there is no need for an ethical board review if written consent has been obtained from the participants, and if there is no physical intervention involved in the study [19]. The study conformed to the principles outlined in the Declaration of Helsinki [20]. Participants were informed that participation was voluntary and that confidentiality would be maintained. Written informed consent was obtained from the participants. Approval for involving the participants in the study was obtained from the hospital board and the surgical ward.

Results

The analysis and interpretation of the collected data in the present study resulted in two main categories and five subcategories. The first category is about communication through interpreters and the second category deals with independence communication with healthcare services (Table 3).

Modes of Interpreting and Potential Difficulties

Professional interpreters

According to the results, even though the use of professional interpreters is mentioned as the best possibility in communication with health care services, some difficulties regarding the use of

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professional interpreters were highlighted by the participants. One female participant stated that she had an appointment at a healthcare center to visit a general practitioner for an abnormal pain in her breast. Instead of the actual illness, she preferred to describe an old difficulty that she had had in her spine, because her interpreter was a man. Unqualified interpreters and differences in mother tongues between the interpreter and patient were other problems emphasized by the participants.

Steps	Description
I	**Meaning unit.** The first step is to identify the words, sentences and paragraph that have the same essential meaning and contain aspects related to each other through their content and context.
II	**Condensed meaning unit description close to the text.** Then meaning units related to each other through their content and context were abstracted and grouped together into a condensed meaning unit, with a description close to the original text.
III	**More condensed meaning unit interpretation of the underlying meaning.** The condensed text in the meaning unit was further abstracted and interpreted as the underlying meaning and labelled with a code.
IV	**Subcategories.** Codes were grouped together based on their relationship and codes that addressed similar issues were grouped together in subcategories.
V	**Categories.** Subcategories that focused on the same problem were brought together in order to create more extensive conceptions.
VI	**Theme.** Finally, a theme that covers the analysed text links the categories that appeared and emerged from the text.
VII	**Direct quotes.** Presentation of result with direct quotes from the interviews.

Table 3. Illustration of the analysis process in various stages (Modified from Lundestam et al).

"There were a number of misunderstandings in communication during the time I used interpreters in my communication with health care services. I do not know if the misunderstandings were rooted in the interpreters' lack of language ability in Swedish or differences in mother tongue between me and my interpreter. We had a different mother tongue - he was a Persian speaking interpreter".

Based on the participants' experiences, the interpreters' lack of knowledge of medical terminology and sometimes insufficient knowledge of the target language were other sources of misunderstanding.

"Now I have mastered the Norwegian language very well. A person who was my interpreter for 20 years ago is my close friend and I know him very well. He is still working as a professional interpreter but I know he has not mastered the target language well, particularly regarding medicine terminology. I don't know, if he interpreted my messages correctly for 20 years. "

Relative or friend as interpreter

The advantages and disadvantages of the use of relatives or friends as interpreters were discussed by participants during the group discussions. "*He was always available to act as interpreter for me, but I never got the opportunity to ask the doctor all I wanted, he always interrupted me, I mean my husband*" said a female participant, who came to Sweden seven years after her husband. Lack of neutrality and language skill, lack of safekeeping and interpreting techniques were some of the disadvantages of using relatives or friends as interpreters, according to the participants' experiences. One participant said:

"I have the kind of disease that means I need frequent communication with healthcare services. It is not easy to appoint a professional interpreter, so I often use my son as interpreter, which he doesn't like and he often tells me that he doesn't want his mother asking him so often. It is a problem".

Theme	Language barrier and practical issues in contact with health care services				
Categories	Modes of interpreting and potential difficulties			Reasons for immigrants' independent contact with healthcare services	
Subcategories	Professional interpreter	Relative or friend as interpreter	ractical aspects	Dissatisfaction with interpreter or exaggeration of language ability	Sufficient language skill
Codes	Unqualified interpreters Misinterpretations Inexperienced interpreters Lack of language knowledge Health terminology deficiency Mother tongue Phone interpretation Cultural aspects Gender perspective	Neutrality Impartially Powerbalance Hidden diseases Language skill Lack of Safekeeping interpreting technique Cultural aspects	Differences in healthcare systems time aspect phone time Waiting time Waiting room	Exaggeration of language knowledge Medical terminology Misunderstanding Hidden diseases Dissatisfaction Confidence	Feeling of autonomy Social benefit Age Gender Different views Filter free communication Independency Feel free

Table 3. Analysis process, codes, subcategories, categories and themes.

Another participant stated:

"Using friends or relatives as interpreters is easy, but often problematic because they may not have enough language knowledge, they are not neutral and often don't know what safekeeping in interpreting means".

Some of the participants stated that diversity in mother tongues between the patient and interpreters sometimes led to misunderstanding in communication between the patient and the health care professional.

"Once I had a Persian speaking interpreter, but my language knowledge in Persian is limited. I was quite dissatisfied with my consultation. I arranged a new appointment for the same problem with a Kurdish interpreter before I left the health care center".

Practical aspects

Apart from linguistic and cultural difficulties, a number of practical issues experienced as problems were highlighted by participants. Time aspects, phone communication difficulties, waiting time, and differences in healthcare systems and physicians' routines were some of the practical issues reported by participants. Waiting time to visit a specialist physician and waiting time on phone lines to be connected to a health care center were mentioned as additional practical issues.

"I had pain in my spine a long time ago; I visited my physician at the health care center. He sent a request form to the orthopedic department at the hospital to arrange an appointment for me to visit an orthopedic doctor. Four months have passed and I am still waiting to visit the orthopedist".

Another participant stated:

"Sometimes it takes less time to go to the health care center than to call and speak with a nurse".

Routines in the health care service, consultations, as well as prescription of medicine during the patient-physician consultation are experienced quite differently by participants in comparison with their home countries. Participants stated that they could often visit a specialist doctor directly in their country, but here one should first visit a general practitioner and only then is it possible to visit a specialist. Regarding the physician's routine during the consultation, one participant said:

"Once I visited my doctor because of a pain in my stomach. I told him I also have headaches and sometimes pain in my ear. He said that he would just investigate my stomach and I must come back another day for the other issues. It was very strange for me. We could tell the doctor about five different diseases at the same time in our country."

Reasons for Immigrants' Independent Contact with Healthcare Services

Dissatisfaction with interpreters or exaggeration of language ability

Dissatisfaction with unqualified interpreters, exaggeration of language knowledge and cultural aspects were factors that caused some of the participants to avoid the use of interpreters, despite the fact that their language skills were limited. "*I believed that my interpreter's language knowledge was at the same level as mine, so I decided to communicate by myself,*" said one participant. Other participants stated that sometimes they exaggerated their language knowledge. If they were satisfied with their daily communication they tried to contact health care services without an interpreter, but communication with health care personnel requires advanced language skills. One said:

"Once my friend had an appointment at the health care center to repairhis teeth. The dentist asked him if he wanted anesthesia, he replied "No, no". The dentist began to drill his teeth, it was certainly painful. When he came home he looked in the Kurdish Danish dictionary and understood what the dentist meant by anesthesia".

Apart from the interpreter's qualifications, the cultural aspect was mentioned by some of the participants as a hampering factor in using interpreters, despite their needs. One participant said:

"In our culture, if someone has a hidden disease, such as epilepsy, it should be hidden from other people. It is not easy to talk about such a disease through an interpreter".

Sufficient language skill

The results showed that many of the participants experienced language dependency as a kind of handicap; in this context they tried to learn the language as soon as possible. Age, gender and previous education in their home countries were mentioned as factors that influenced learning the language in the resettlement countries. *"My wife is 12 years younger than me and you know women like to speak all the time, so she speaks Danish better than me"*, a participant said with a smile. Although three of the participants still need an interpreter in contact with health care services, the majority of them are now able to have independent communication with health care service. This issue was addressed as an important topic in the participants' lives in resettlement countries. One participant said:

"When I was sure that my language skill was good enough for independent communication with the health care services I felt that I was a free person. I could tell the doctor all I wanted".

Some of the participants stated that learning the language of the country they had come to has mutual benefit. One of them said:

"Learning Swedish not only leads to independence and freedom, but is also a way to access health care services and to save money".

One of the participants called independent communication with health care services, *"filter free communication"*.

Discussion

The present study deals with human experiences of communication, so the qualitative content analysis method was suitable for analysis of the collected data. This method makes it possible to analyse large amounts of data in a systematic way, compressing large texts into a limited number of content categories, using defined rules of coding [16]. On the other hand, this method primarily deals with more objective and quantitative descriptions of the manifest content of communication [21]. As our study deals with communication, this method is appropriate for analysis of the collected data.

The results of the study indicate that Kurdish refugees experience a number of difficulties in communication with health care services, both through interpreters and in independent communication. Additionally they reported problems regarding practical issues during their contact with healthcare service. Although the study was conducted in three countries, with three different healthcare systems,

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the problems that were reported were mainly similar. In communication through interpreters, using unqualified professional interpreters and relatives as interpreters were highlighted as problems by the participants. It is not sufficient to speak two languages to act as a health care interpreter. There are factors beyond language that may lead to misunderstandings, factors such as health beliefs, concepts of disease and constraints in the expression of health and illness in different cultures [22]. Even though the interpreters' language knowledge has a central role in consultation, professional interpreters should be able to interpret the cultural and emotional aspects in consultation, as well as the language [23]. The importance of qualified professional interpreters regarding patient satisfaction and health outcome for refugees was also indicated by previous studies [22]. Using professional interpreters in health care communication would lead to significantly fewer misunderstandings and better health outcomes [24].

The previous study indicated that there are obvious differences in communication outcome when relatives are used as interpreters compared with professional interpreters [25]. Concerning relatives or friends as interpreters, relatives' impartiality as well as their lack of language knowledge was mentioned by participants as obstacles in communication through an interpreter. Due to the high cost of interpreting services, sometimes relatives or friends are used as interpreters. A pilot study in Sweden showed that in 39% of cases when an interpreter was needed, a relative or friend acted as interpreter, of which 6% were children [26]. Using a relative, particularly a child, as interpreter should be avoided, because often their language competence is unsatisfactory for consultation in a health care setting. Children should never be burdened by such a duty, since it may influence their mental health. The study results showed how a child that was used regularly as interpreter for his mother, was affected by the subject of the interpretation. Inhabitants in Scandinavian counties represent real cultural diversities; in this way cross-cultural healthcare communication is now a part of the daily work of healthcare professionals in these countries. To overcome difficulties and prevent misunderstandings in communication requires an adequate understanding of similarities and differences in health beliefs, and knowledge about factors that may influence cross-cultural healthcare communication [27]. In cases when a third person needs to be involved to facilitate health communication, a qualified professional interpreter should be used rather than the patient's friend or family member, particularly children [28].

Some of the participants stated that they had begun to make direct communication with health care services and avoid the use of interpreters after a few years in their resettlement countries. The most mentioned reason for this was dissatisfaction with the interpreters' language competence. This is in line with the results of a previous study in Sweden [16]. The results showed that some participants, who did not have an accurate evaluation of their language skills, began independent communication with health care services. When they were able to make communication with the native population in their daily social activities, they also tried to make direct communication with health care services, which requires advanced language skill. This exaggerated view that some of the participants had of their language knowledge resulted in misunderstandings in communication with health care services. Other participants began to make direct communication with health care services when they were sure that their language skill was good enough for independent communication. They described this event as an important issue in their lives, and language ability was mentioned by participants as key to their new life in their resettlement countries. Lack of impartially and the participants' fear of describing their problems openly during the consultation through an interpreter were additional problems addressed in this study. This issue has been addressed in a previous study [29]. According to the participants, the experience of talking about hidden diseases through an interpreter is not easy in their culture. "*To accept and talk about certain diseases, such as epilepsy and mental problems, may be difficult in certain cultures*"[3].

Study Limitations and Strengths

Since the study deals with individuals' experiences regarding their private life it would have been better to have separate group discussion with the female participants led by a female researcher. Due to cultural aspects in some ethnic groups it is difficult for a woman to express herself emotionally when unknown men are present in the same group. Unfortunately because of financial problems and the lack of a female researcher, it was not possible to arrange separate discussion groups for female participants. Another limitation may be thatthe number of participants was small and they were from the same ethnic group (Kurdish). The investigator in the present study belongs to the same ethnic group as the participants, which may be considered a risk factor for impartiality in the planning, execution and analysis of the research, because of pre-understanding [30]. Although some bias due to the investigator's background and pre-understanding cannot be ruled out, the degree of openness, depth and confidence obtained in the interview situations probably out-performed potential biases that could not be ruled out completely. Furthermore, bias in the research process was probably limited by the investigators' awareness of the limitations of qualitative methods, and awareness of the impact of the "life-world paradigm" regarding pre-understanding. The strengths of this study are the variety of genders, ages and occupations among the participants, and the group discussions were carried out in a neutral setting (Kurdish cultural association centers in the respective countries). The study was carried out in three countries. Additionally, the participants could use their own mother tongue in all group discussions, in this way the risk of misunderstanding was minimal.

Conclusion

A number of difficulties concerning the Kurdish refugees' communication with health care services in Scandinavian countries were revealed by the present study. Interpreters' linguistic incompetence, their relatives' impartially and lack of language knowledge in communication through interpreters were problems mentioned by participants. Dissatisfaction with professional interpreters' competence, exaggeration of their own language ability by some of the participants and sufficient language knowledge were motives for Kurdish refugees to tend to make independent communication with health care services. Diversity in health care service routines and the physician's methods regarding consultation and prescription of medication, as well cultural aspects and practical issues, were highlighted by participants in the present study.

Competing Interests

The authors declare that they have no competing interests.

Author Contributions

The Main Author Nabi Fatahi initiated the study, conducted the interviews and performed the data analysis. All authors drafted the manuscript and did critical revisions.

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