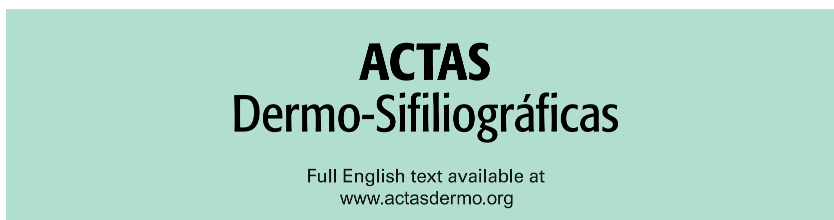
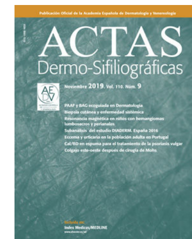
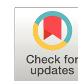
ACTAS Dermo-Sifiliográficas 112 (2021) 779–780





OPINION ARTICLE

Communicating With Migrant Patients: An Unsolved Problem?☆



La comunicación con el paciente migrante: ¿asignatura pendiente?

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Although human communication is our main means of organizing a society, it also presents us with major problems today.[1]

Physician-to-patient communication is one of the most important skills health professionals must acquire during training,[2,3] yet doctors have been shown to be very poor communicators.[4]

Net population growth in Spain in recent years has mainly been due to immigration, which has risen gradually to maintain a positive net migration rate (immigrants − emigrants). Meanwhile, the vegetative balance (between births and deaths) continues to be negative. The Spanish Statistical Office (Institute Nacional de Estadística) reported that as of January 1, 2020, 11.06% of residents were noncitizens. The proportion is notably higher in some areas.

One consequence is an increased demand for health care from patients from cultures other than Spain's.[5] A patient's culture affects lifestyle, perception of disease, and what is expected and required of a health care system.[6,7]

It is important to remember that health care for migrants is not equivalent to medicine centered on rare parasitic and viral diseases. Rather, it is medical care for men and women who have left one health system behind without abandoning it entirely, migrants who have acquired a new system they do not yet understand; the 2 systems differ in how they express suffering and how they conceptualize disease, pain, death, and the medical act.[8]

When physician and patient fail to communicate, quality of care can be seriously harmed,[9] making it difficult to comply with the principles of medical ethics.[10]

One study carried out in a Spanish primary care setting showed that although language is the first obstacle to overcome when communicating with migrant patients − and is one that often interferes with identifying symptoms − additional problems can be introduced by ''mediators'' (family, friends, neighbors, etc.)[11] because of the varying notions of disease at work in different ethnic groups.[12]

For use in such contexts, the figure of ''intercultural mediator'' was developed. This figure belongs to the patient's culture, is recognized as such, and is able to negotiate between the 2 cultures.[13,14] We must not forget, however, that the mediator is a third party who may also potentially interpret and transmit information incorrectly.

Thus, we agree with other authors that language is not the sole problem in communication.[15] Several others are in play. Some are patient-related. Examples are marginalization, an uncertain legal status, the migratory duel between cultures, lack of understanding of how the health system works, less continuity of care due to family or socioeconomic problems, and lower awareness of health campaigns carried out in a language different from the patient's native one.

☆ Please cite this article as: Díaz-Díaz RM, Alcalde Alonso MM. La comunicación con el paciente migrante: ¿asignatura pendiente? Actas Dermosifiliogr. 2021;112:779–780.

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We also believe there are health care staff-related factors. Staff, who are under pressure from high caseloads, must make an extra effort with migrant patients in the short time that is available, sometimes making verbal communication more difficult and diminishing nonverbal communication. In this situation, patients can become victims of prejudice or disrespect if they are labeled ''difficult.'' The health caregiver may fail to perceive the feedback required to confirm whether professional and affective acts are effective or not.

A literal translation of what the patient explains seems to be inadequate for overcoming communication obstacles.[6]

One reason lies in the difficulty of establishing equivalents between languages, or failing to appreciate subtle differences in meaning whereby concepts can become lost in translation. Another lies in the additive effect of grammatical artifacts that occur when each of the interlocutors uses a language with structural differences, or when they communicate in a shared language they may speak and understand only imperfectly. Morphology and syntax that are transferred may then introduce confusion. An example is the statement/question ''You haven't been taking your tablets?'' (*¿No ha tomado las pastillas*?) — to which an English speaker wishing to confirm that this negative construction is correct, would answer ''no,'' whereas the Spanish speaker would reply *sí*, and so there develops a situation in which ''no'' can convey ''yes'' (and vice versa) to a listener. In addition to telephone or in-person interpretation services and the previously mentioned intercultural mediators, graphic communication tools have been developed to depict concepts, accompanied by labels in different languages.[16]

Finally, we summarize some of the recommendations to bear in mind when communicating with migrant patients[17,18]:

1 Acquire knowledge of features of the patient's culture (transcultural medicine).
2 Avoid obstacles such as interruptions, noise, parallel conversations, or the use of specialized terminology.
3 Facilitate communication: recognize the presence of the interpreter and maintain a triangular position with respect to him or her and the patient. Address the patient, speak slowly and clearly to express a concrete message, and reinforce the patient's understanding.
4 Use multilingual pictograms and graphic aids in different languages.
5 Express empathy throughout the communication process.

Funding

This paper received no type of funding.

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