Immigrants in emergency care: Swedish health care staff’s experiences

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Background: During the past few decades Sweden has developed into a multicultural society. The proportion of patients with different cultural backgrounds increases, which naturally makes new demands on health care staff.

Aim: To identify whether staff in somatic and psychiatric emergency care experienced problems in the care of migrants, and if so to compare these.

Method: The study design was explorative. Focus group interviews of 22 women and 13 men working as nurses and assistant nurses at an emergency ward, an ambulance service and a psychiatric intensive care unit were held.

Findings: The results showed that the main problems experienced in all wards were difficulties related to caring for asylum-seeking refugees. Some dissimilarities were revealed: unexpected behaviours in migrants related to cultural differences described by staff working in the emergency ward; migrants’ refusal to eat and drink and their inactive behaviour in the psychiatric ward; and a lot of non-emergency runs by the ambulance staff because of language barriers between the emergency services centre and migrants.

Conclusion: The main problems experienced by the health care staff were situations in which they were confronted with the need to care for asylum-seeking refugees.

Practice implications: These emphasize the importance of support from organizational structures and national policies to develop models for caring for asylum-seeking refugees. Simple routines and facilities to communicate with foreign-language-speaking migrants need to be developed. Health care staff need a deeper understanding of individual needs in the light of migrational and cultural background.

Keywords: Ambulance, Asylum-seeking Refugees, Emergency, Health Care Staff, Migrants, Psychiatry

Introduction

During the past few decades, Sweden has changed into a multicultural society with over 100 nationalities represented (Ekblad et al. 2000). Nearly 11% of the Swedish population (8.9 million) have a foreign background, nearly one fifth if the second generation is included. The migrant population in Sweden is dominated by European labour migrants (SOS 2003), but in the last 5 years 28% of the migrants have been asylum-seeking refugees (Socialstyrelsen 2003). The increased number of migrants makes new demands on health care staff (Ekblad et al. 2000). Encounters prove different depending on the aim and direction of emergency care. Emergency care is often characterized by brief encounters between health care staff and the patient (Ozolins & Hjelm 2003). The patient may be in a bad way and at times unconscious and therefore vulnerable (Andersson 1994). The migrant population may be particularly vulnerable because of forced migration and traumatic experiences such as war, persecution and torture (Ottosson 2000; Södergard & Ekblad 1998). The ability to adapt to the new society and different cultural beliefs about health and ill-
ness might also affect their well-being (Hull 1979; Litz & Gray 2002). It has been shown that a covariation exists between suicide and immigrants suffering from post-traumatic stress syndrome (PTSD) (Ferrada-Noli et al. 1996; Khan et al. 2002; Marcello et al. 1996). The migration process may entail changes affecting the immunological defence system negatively (Hull 1979).

Beliefs about the causes and treatment of mental illness may differ between and within cultures (Beiser 2003; Rosenbaum 1991). Culturally determined ideas, values and behaviours must be understood from an individual perspective. Barriers to communication between health care staff and patients could lead to misunderstandings and increase the risk of misdiagnosis and inappropriate treatment (Hjelm et al. 1998; Robinson & Gilmartin 2002). This was demonstrated in a study of native Spanish-speaking patients who also spoke English. The patients were diagnosed with schizophrenia, and rated a higher level of symptoms when not interviewed in their mother tongue (Stolk et al. 1998).

A limited number of empirical studies concern migrants in emergency care. The studies are mainly quantitative, have been published in the USA and focus on care-seeking behaviour and use of emergency care (Chan et al. 1996; Finnega et al. 2000; Zambrana et al. 1994). Beliefs about mental health and illness among different cultures were described in one study (Beiser 2003). A Swedish explorative investigation found communication difficulties including language barriers and cultural dissimilarities to be the main problems experienced by nurses caring for migrants in emergency care (Ozolins & Hjelm 2003). However, the study did not discuss whether there are dissimilarities in problems experienced in different areas of emergency care, which need to be further studied. It is important to explore and describe situations in the encounter with immigrants to develop culturally congruent care and increase awareness and comprehension of differences (Leininger 2001). To sum up, only a limited number of international and national studies focusing on health care staff’s experiences of care of migrants in emergency care have been found in the literature review. No studies were found investigating dissimilarities between somatic and psychiatric emergency care.

**Aim**
The aim of this study was to identify whether health care staff in somatic and psychiatric emergency care experienced any problems in the care of migrants, and if so to compare their experiences.

**Definition**
In this study, the term migrants refers to persons born in a country other than Sweden, including persons immigrating voluntarily or under duress (immigrants and refugees).

**Theoretical framework**
The development of cultural diversity is dependent on different structural elements that must be taken into consideration, such as technological factors, religion/philosophy, friendship/social relationships, cultural values and lifestyles, political and legal factors, economic factors and educational factors (Leininger 2001).

Each individual is unique and should, according to Giger et al.’s model (2002), be assessed according to six cultural phenomena: communication, distance or space, social orientation, time, possibility to influence the environment and biological variations. There are diversities between cultures and also within the same culture. By systematically exploring phenomena, one can illuminate the aspects that are needed to develop culturally congruent care, which increases the understanding of cognitive patterns, psychosomatic activities, attitudes and individual appraisals.

**Methods**

**Study design**
As the field has not previously been explored and the study sought to understand the reality, an explorative qualitative method using semi-structured focus group interviews was chosen (Patton 2002). The group process facilitates the members’ ability to express and clarify their beliefs, to experience and uncover more or less unconscious beliefs and understanding which may not have disclosed in an individual interview (Krueger 1998a). In comparison to individual interviews, the group situation makes people feel safer and they often get ‘carried away’ by the discussions.

**Sampling procedure**
The managers of the somatic emergency clinic, the ambulance service and the psychiatric emergency clinic at a regional hospital in southern Sweden, were contacted by telephone. A time when information about the study could be given was set and written approval for the studies was obtained at the meeting. The managers were requested to invite staff with 2 years of experiences in health care to participate. Written information was sent by e-mail to all staff at three selected wards: an emergency ward, the ambulance service and the psychiatric intensive care unit. Those who were willing to participate contacted the manager. Times were set for interviews. Consideration was given to the staff’s working schedule. The interviews were carried out at each ward.

**Settings**
The interviews were implemented at these three sites. Care in an emergency ward is characterized by assessment of an individual’s status and first aid measures in order to cure or refer the patient for further care. Care in the ambulance service is limited to life-
sustaining measures and transportation to the hospital. Care delivered at the psychiatric intensive care unit is focused on acute measures related to severe dysfunction of behaviour, mood, thinking or perception that might create a threat to life, adequate functioning or psychological integrity. All settings are characterized by a high-technological environment and with brief encounters between staff and patient (Newberry 1998).

Procedure and participants
Before each interview a written structured questionnaire was filled out by each respondent concerning education and work experience. The study population consisted of 22 women and 13 men with varying professional experience and varying education in each ward (Table 1). The focus group interviews were led by a psychiatric nurse (moderator; first author). A nurse with experience of somatic emergency care participated as facilitator (second author). Three interviews were carried out in each emergency site. In total nine groups were held including 35 participants during November and December 2003. Each focus group interview included three to six participants and took 1.5–2 h in free-flowing discussions following a semi-structured interview guide. The interviews were audiotaped and transcribed verbatim. The texts were coherent and showed a high quality.

Analysis of data
According to Krueger (1998b) collection and analyses of data proceeded simultaneously and the principle of saturation guided the study. Thus, the analyses proceeded until no new information emerged. Three focus groups in general need to be held within each area before saturation is reached. The analyses were performed in accordance with the method described for focus group interviews (Krueger & Casey 2000). The texts were analysed independently by two persons (first and second author), showing high agreement. The text was read several times to give a comprehensive picture. All opinions connected to the participants’ experiences of encounters with migrants were marked with a highlighter and memoranda were written in the margin. Words and opinions with similar meanings were brought together in subcategories. Comparisons were made during the whole analysis between the subcategories and the text as a whole. The aim of the analysis was to discover regularities, contradictions, patterns and themes in the text (Patton 2002). Different subcategories were shaped, and when no new interpretations of the text appeared, the subcategories with similar meaning were brought together into one main category. The main categories were shaped on the basis of differences in the subcategories in such a way that they are distinguished from each other. The names given to the categories are as close to the terms in the original text as possible and sum up the meaning of the category (Krueger & Casey 2000).

Ethical considerations
The study was approved by the Ethics Committee of Lund University, and was carried out with written informed consent from the respondents, and in accordance with the four standards of individual protection (Medicinska forskningsrådet 2003).

Findings
The overall picture of the text showed that there were similarities in the experiences of staff at different emergency wards (Table 2). The main problem described was difficulties arising when caring for asylum-seeking refugees. Specific situations illustrated how migrants behaved in unexpected ways related to cultural differences and languages barriers, and how it could be difficult to handle the large number of people around the patient. When

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Table 1 Characteristics of the study population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Emergency care N = 12</th>
<th>Ambulance N = 12</th>
<th>Psychiatric intensive care N = 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (n)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Age (year)*</td>
<td>42 (24–54)</td>
<td>41 (32–51)</td>
<td>45 (31–56)</td>
</tr>
<tr>
<td>Education (n)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>12</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Assistant nurse</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Postgraduate training for nurses in emergency care</td>
<td>4</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Experience of work in health care (year)*</td>
<td>21 (1.5–36)</td>
<td>19 (11–28)</td>
<td>16 (2–38)</td>
</tr>
<tr>
<td>Number of years at present place of work (year)*</td>
<td>8.6 (0.2–16)</td>
<td>11 (0.5–20)</td>
<td>3 (0.2–2.9)</td>
</tr>
</tbody>
</table>

*Values are median (range).
Table 2 Overview of main categories with accompanying subcategories as described by staff working in a psychiatric intensive care unit, ambulance service and an emergency ward

<table>
<thead>
<tr>
<th>Category</th>
<th>Psychiatric intensive care unit</th>
<th>Ambulance service</th>
<th>Emergency ward</th>
<th>Total number of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of statements</td>
<td>No. of statements</td>
<td>No. of statements</td>
<td></td>
</tr>
<tr>
<td>Asylum-seeking refugees</td>
<td>65</td>
<td>32</td>
<td>29</td>
<td>126</td>
</tr>
<tr>
<td>• Malingering</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The main problem is refusal of a residence permit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recommended to seek psychiatric care to receive a certificate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Interpreter charges asylum-seeking refugees even though it is not necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties related to different cultural behaviours</td>
<td>27</td>
<td>21</td>
<td>21</td>
<td>69</td>
</tr>
<tr>
<td>• Difficulties in motivating cooperation in the treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Different expectations of health care</td>
<td></td>
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<td></td>
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<tr>
<td>• Apparent more emotional and loud</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Behaviours related to cultural ceremonies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The staff felt limited knowledge about other cultures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties related to contact with relatives</td>
<td>24</td>
<td>18</td>
<td>18</td>
<td>60</td>
</tr>
<tr>
<td>• The children are in a precarious situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Many persons around the patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mental pressure of the whole family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Change of gender roles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Limited social network in Sweden</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complicating organizational factors</td>
<td>12</td>
<td>15</td>
<td>15</td>
<td>42</td>
</tr>
<tr>
<td>• Difficulties in finding an interpreter, especially at night, and minority language</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Limited knowledge about Swedish health care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Shortage of health care staff at the refugee organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties related to gender roles</td>
<td>10</td>
<td>15</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>• Women are not allowed to act because of the husband</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Important with the same gender on caregiver and patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties related to earlier experiences of migration</td>
<td>6</td>
<td>12</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>• Post-traumatic stress syndrome, experiences of war or rape</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language barriers</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>• Communication barriers related to different languages</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reliability of relatives acting as interpreters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situations perceived as threatening</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>• People perceived as threatening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Parities and effects of drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties related to earlier experiences of migration</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>• Post-traumatic stress syndrome, or loss of established diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reliance on health care staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uniform viewed as a symbol of power</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of statements</td>
<td>151</td>
<td>125</td>
<td>118</td>
<td></td>
</tr>
</tbody>
</table>
differences between the wards were examined, it was found that staff in emergency care experienced more difficulties in managing behaviours related to cultural dissimilarities, and they felt a great burden of responsibility in deciding whether or not the non-Swedish-speaking migrants were in need of emergency care when calling on the phone. Staff in the ambulance service often described migrants’ limited knowledge of the Swedish health care system, and thus called the emergency services centre often. Because of language barriers between the staff at the emergency services centre and migrants, the ambulance did a lot of non-emergency runs. Staff at the psychiatric intensive care unit described difficulties concerning certificates for asylum-seeking refugees. Children were put in precarious situations because of the parent’s illness, and there were situations where the nurse had problems in caring for patients as they were passive and refused to eat and drink.

In the following, the main categories with the accompanying subcategories supported by illustrative quotations are introduced.

Differences related to care of asylum-seeking refugees
Staff in all wards distinguished asylum-seeking refugees in the group of migrants because of the different kind of problems encountered. The problems related to asylum-seeking refugees formed the category with the largest number of situations described by staff. They dominated the difficulties experienced at the psychiatric intensive care unit and the ambulance service. Staff at the emergency ward also experienced the problems. For example, when an asylum-seeking refugee was refused a residence permit or received a deportation order,

We can’t influence their application for asylum, and that’s the kind of help they want. . . .

Staff noticed a tendency for asylum-seeking refugees to imitate others who had been in the same situation.

If we do like they did we might have a chance to stay. We have had situations where it has been obvious afterwards that they were just faking.

Malingering was most frequently described by staff working at the psychiatric intensive care unit but had also been noticed occasionally by staff in the ambulance service. Staff in the emergency ward had not reflected on this problem.

A further problem was that asylum-seeking refugees were reported to be recommended by lawyers to seek health care or to overdose on tablets. Staff mentioned that patients told how they were urged by lawyers to ‘try to commit suicide to receive health care, and the lawyers call asking for certificates . . . they want to have a psychiatric diagnosis to make it easier for them to stay.’

Other situations illustrate that the health care staff experienced difficulties when passing asylum-seeking refugees on. Staff at the emergency ward described the problems as losing faith in other health care institutions.

The welfare centre has no time . . . but we have nowhere to pass them on to. When the patients that have overdosed return again we refer them . . . and then they come back again two days later with an overdose again. It happens over and over. Then you begin to lose faith.

Difficulties related to different cultural behaviours
A recurrent problem was unexpected behaviours shown by patients or relatives. This was predominantly described by staff in emergency care. Staff in psychiatric intensive care and the ambulance service experienced this as the second largest difficulty after asylum-seeking refugees, expressed as:

I have found that they show it a little more easily or faster than we do. They are louder. It is often more dramatic around migrants, they tear their hair in despair and they cry with more emotion.

Staff sometimes experienced difficulties in assessing the seriousness of illness because of the different behaviour. All wards described how migrants had a more intensive mode of communication, both verbal and non-verbal.

Staff in the emergency care recounted that: ‘Not all of them have the knowledge that we have, even if it’s not trained health care staff but what the general public in our countries know about their own body.’ Behaviours involving risks appeared distinctly.

When it comes to road accidents, most of the ones involved in road accidents have worn seatbelts but migrants often don’t wear seatbelts. That makes the injuries worse.

Limited knowledge about behaviours related to different cultures sometimes causes difficulties for health care staff when being confronted with different cultural traditions and ceremonies.

We don’t know anything about how to handle these situations in cultural and maybe religious terms.

This problem mainly occurred in the ambulance service but was also experienced at the emergency ward. Staff in psychiatric intensive care called for education and exchange of experience regarding migrants.

Only staff working in psychiatric intensive care described problems with patients who refused to eat or drink.

They have a constant headache, they never move and they don’t eat, they don’t drink a lot and they smoke.
They also described problems in treatment related to patients being passive.

They just lie in bed not wanting to participate at all, it feels like.

**Difficulties related to contact with relatives**

Difficult situations sometimes arose between health care staff, the patient and relatives. Persons working in the ambulance service and the emergency ward mainly described difficulties in managing a crowd of people around the patient.

Often you have to take care . . . of the relatives and the patient so it takes longer. People standing all over and they don’t move so you almost have to push them away. There have been a couple of times when I have had to unload people from the ambulance to make room for myself.

An example, in the psychiatric intensive care unit was: ‘The mother doesn’t want to face the kids. It can be a two- or three-year-old coming to hug the mother and she turns away, doesn’t even look at them. Then she pushes them away.’

The staff also described situations like: ‘A woman called for me and my colleague so that we could watch her hit her kid.’

Informants also recalled situations where kids had to take heavy responsibility.

The woman said nothing, it was all through her daughter. She carried all the responsibility, it’s often like that.

Further situations concerned families living under great mental strain.

The husband is in hospital and the whole family is in hospital, it can be completely chaotic. The older kids are with relatives or have disappeared underground being hidden somewhere.

Finally, problems occurred related to persons having limited or no social network in Sweden.

Often we gather information from relatives, friends, and the information is very important, but they have no network.

**Difficulties related to gender roles**

Changes in the gender roles appear problematic, and the informants described situations when the husband became unable to act when the wife was in hospital and he was expected to take care of the children and the home.

Staff in all units described the importance of having the person receive care from a staff member of the same gender. At the psychiatric intensive care unit this occurred mainly in situations in which the woman was not allowed to act because of her husband.

They sometimes have a different view of women in other cultures. They say it’s the man who should talk to us, not the woman, even if she’s the one who’s sick. Women especially are difficult. When we have to undress them and they don’t want to let a man close.

**Complicating organizational factors**

The staff described situations that could be related to difficulties in the organizational structure. Those working at the psychiatric intensive care unit and the emergency ward spoke of trouble in finding interpreters as the main problem in this category.

Staff distinctly described how migrants often had limited knowledge about the Swedish health care system:

They don’t know where to turn for help so they call the emergency services centre for help.

It further appeared that the staff found it a great responsibility to decide whether foreign-speaking migrants were in need of emergency care or not when they phoned the emergency ward.

We are trapped because if we bring them here and they are not in need of emergency care we get a scolding.

There were comments on the shortage of health care staff at the refugee camp:

There are too few of them. More resources are needed for medical service at the refugee locations.

Staff said they did not know what information had been given to migrants:

Do migrants know where to turn for help, or why do they come for help in the evenings and at night?

Frustrating experiences were related to difficulties among the staff in finding appropriate interpreters of the right gender, especially at night and in minority languages.

We need interpreters very often. It’s difficult to find an interpreter when you need one.

**Language barriers**

Another problem, experienced in all studied areas of emergency care, was related to communication barriers mostly because of language. This caused trouble in interchange of information between staff and patient and also in assessments.

Information is a great problem, we have a lot of information to give them, it’s difficult to understand what the problem is and it’s hard for us to form an opinion because of the communication barriers.
The most difficult communication barrier was perceived between the emergency services centre and the patient and was described by those working in the ambulance service:

We did an emergency run because we were told he had a terrible headache; when we got there he was suffering from inflammation of the ear, he came to the wrong place. They don’t understand each other, the emergency services centre and the patient, and they don’t want to take any risk so often they just send an ambulance to check what’s wrong with them.

Furthermore, staff described difficulties in trusting in neighbours and relatives as interpreters as they felt they did not always translate everything that was said.

**Difficulties related to earlier experiences of migration**

Situations illustrated how earlier traumatic experiences (e.g. PTSD) could influence migrants in different ways. Migrants suffering from PTSD were found in all kind of wards. Staff working in psychiatric intensive care described experiences of persons suffering from PTSD which could be related to rape. Persons working in the ambulance service had difficulties, as PTSD might lead to other diagnoses being overlooked.

Asylum seeking refugees who suffer from PTSD and are in a major depression . . . woman who has also been subjected to rape during the war. Talk about degradation, the woman become totally worthless. It's hard to put oneself in their situation . . . understand what it is really about. The treatment is rather special.

Staff also described how flashbacks from traumatic experiences of war sometimes struck the patients.

The police stopped him . . . It aroused a lot of memories and he was full of anxiety and then got pains in his chest. With his way of expressing things we thought he was suffering from a heart attack. We were totally wrong.

**Situations perceived as threatening**

Staff also described situations that were found threatening, for example, men get angry when their women are discharged from hospital, and they threaten the doctor.

Persons working in the ambulance service sometimes were involved in situations that one can feel unpleasant sometimes, with drugs and things like that involved, . . . partying and violence.

Sometimes uniforms were interpreted as symbols of power, which was described by staff at the emergency ward and the ambulance service as:
qualitative studies can be transferred to similar contexts and persons (Krueger & Casey 2000).

Through the focus group interview, it was easy to illustrate similarities and dissimilarities between staff working in different areas of emergency care. Problems revealed in the encounters in caring for migrants in this study differ from the results in the previous study (Ozolins & Hjelm 2003), most likely due to the different methods chosen and also the participants’ demographic background. The respondents also worked in an area with a migrant population similar to that of other medium-sized Swedish towns (SOS 2003).

According to Kitzinger & Barbour (1999), it is important to show great flexibility when gathering data and it is necessary to try to observe voices that otherwise may not be heard. During the interviews the facilitator noted and reflected on the group dynamics. The notes were discussed after each interview and led to a higher awareness of the interaction in the group. The combined experience of somatic and psychiatric care was advantageous in collecting data from all participants. During one interview the facilitator discovered that the participants had misunderstood the aim of the study and thought that it was to investigate racist ideas and attitudes. This was then discussed with the respondents during the coffee break and then the climate in the group changed, so this was no longer a problem. In the subsequent interviews the content of the aim was further emphasized in order to avoid this misunderstanding. The sampling procedure of inviting all staff at the departments might have meant that both those interested in the field and those who wished to express their opinions were represented. Thus, the results might reflect both positive and negative attitudes to migrants. However, the study is limited as the scope of the patients and relatives has not been investigated. The aim of the study was exploratory and intended to obtain ideas for planning further studies. Thus, further investigations are needed to get a more complete picture of the reality.

Findings

All respondents distinguished asylum-seeking refugees from migrants. Asylum-seeking refugees were in the category who put staff in the most problematic situations in emergency care and evoked strong emotions such as frustration. Research has demonstrated that caring for asylum-seeking refugees brings specific problems such as deportation orders and appeals against them, certificate procedures and malingering (Socialstyrelsen 2003), as clearly demonstrated in this study. Applications for residence permits for asylum-seekers are handled by the Swedish Migration Board and may take 3–6 months from the application time. The majority who receive a deportation order appeal against the decision which leads to further waiting. The average waiting time is 1–2 years in total before the final decision. While waiting the asylum-seeking person has the choice of staying at the refugee camp or moving to an apartment in the community (Migrationsverket 2004). Migrants, especially asylum-seekers, are a particularly vulnerable group as they are exposed to stress related to waiting for residence permits, migrational background and adaptation in a new environment (Hull 1979; Södergard & Eklad 1998), and this is vitally important for all health care staff to recognize. The stress aroused might affect behaviour (Ottosson 2000) both in the individual and those nearest, and the behavioural change might be interpreted as cultural dissimilarities. Knowledge about different groups of people is essential if care is to be culturally congruent (Campinha-Bacote 2002; Leininger 2001).

In this study health care staff described being placed in situations where they were unable to help people who were suffering, particularly asylum-seeking refugees. There are no institutions to which they can be referred for continued care. National guidelines for caring for asylum-seeking refugees have been developed by the National Board of Health and Welfare (Socialstyrelsen 2003), but this study confirmed lack of knowledge about these. It is essential to spread knowledge about existing guidelines among different health care institutions. Problems in caring for asylum-seeking refugees were not observed in a previous study (Ozolins & Hjelm 2003), which may be due to the participants’ limited experience of work in emergency care. The development, organization and function of the health care system are dependent on structural elements such as societal, economic and political factors (Leininger 2001) and thus changes need to be made at the structural level.

Staff in the ambulance service and at the emergency ward described organizational difficulties in terms of limited knowledge in migrants about the health care system and where to seek help, as previously shown (Sachs 1983). The ambulance service might be sent to the patient to investigate the situation although it is unnecessary, which might lead to delayed treatment and requirements for more health care resources. The participants expressed wishes for translated information about where to turn for help to be spread at refugee camps and welfare centres. The information would make it easier for migrants to find their way through the health care system and contribute to more cost-effective health care.

Staff at the psychiatric intensive care unit described difficulties in motivating patients to become active in the treatment when having no access to or difficulties in finding appropriate interpreters, especially at night. Thus, communication barriers are commonly found to be problematic in the encounter between health care staff and migrants, which is in accordance with previous research (Bayard-Burfield et al. 2001; Giger et al. 2002; Leininger 2001; Robinson & Gilmartin 2002). The ambulance have no access to interpreters and thus the communication was by sign
language and facial expressions, which might increase the problems as both verbal and non-verbal communication and behaviours differ between cultures (Helman 2000). Language barriers between health care staff and the patient might lead to incorrect assessments, inappropriate care for the patient and risk of misdiagnosis (Ekblad et al. 2000; Hjelm et al. 1999; Robinson & Gilmartin 2002; Stolk et al. 1998). This study evinces difficulties in communication related to language barriers in all the emergency wards studied. Previous research has shown that when language barriers occur it might be difficult to know that information given is perceived correctly (Hjelm et al. 1998). Staff in this investigation desired interpreter services 24 h a day, which raises the question whether it is possible to have interpreting over the telephone or using other technical solutions. Streamlined routines for communication with foreign-language-speaking persons contribute to cost-effective and high-quality care.

Another problem reported in this study was related to different behaviours. Verbal and non-verbal communication were specified during the interviews as important in providing decent care to migrants. It has been shown (Giger et al. 2002) that although staff and patient speak the same language, misunderstandings may arise because of dissimilarities in verbal and non-verbal behaviours. It is essential that nurses have an awareness and appreciation of the role that body language may have in the communication process (Giger et al. 1995). In this study it appeared that staff sometimes felt frustrated when they were unable to understand and help the patient because of the different behaviour. Behaviours are related to different cultures. Culture influences how feelings are expressed and what verbal and non-verbal expressions are accepted (Giger et al. 2002; Helman 2000). On the other hand, nurses must be cautious that certain patterns of expression can be limited to one family. Therefore the nurse should keep in mind common cultural patterns and approach the client as an individual who should not be categorized because of cultural heritage (Giger et al. 2002). Staff in this study felt limited knowledge about different cultures. The changing demographics and economics with the growing multiculturally and ethnically diverse society have challenged health care professionals to consider cultural competence a priority (Chan et al. 1996). In order not to impose one’s own beliefs, values, practices and patterns on people from another culture, one must be aware of one’s own cultural values (Ekblad et al. 2000; Leininger 2001). During one interview there was a discussion concerning cultural dissemination within a group and whether specific knowledge about cultures and languages could be provided in order to arrive at better descriptions of cultural differences among migrants.

Previous research shows that migrants have different expectations of health care and there are differences among cultures in beliefs about health and illness (Hjelm et al. 2003). The staff also described behaviours involving risk, as is clearly apparent when in traffic accidents. Migrants were reported to use seatbelts infrequently, leading to increased injuries in road accidents. During the interviews it emerged that persons involved in accidents sometimes had been in Sweden without a residence permit. Previous research has shown that 8.6% of persons seeking care in an emergency ward in the USA were in the country illegally, so the existence of illegal immigrants has become a vital topic of discussion in developing a policy for the organization of health care (Chan et al. 1996).

Migrants and asylum-seeking refugees constitute a particularly vulnerable group of people as regards their health (Ottosson 2000; Södergard & Ekblad 1998), so it is important that further research contributes to high-quality, cost-effective and above all individually designed and culturally adapted evidence-based care.

Conclusion
This study shows that health care staff at all wards distinguished asylum-seeking refugees from immigrants because of the different kinds of problems encountered when caring for them.

Implications for practice
The results of this study emphasize the need of support from organizational structures and shared models especially developed for health care of asylum-seeking refugees. Effective and simple routines and facilities are also necessary when communicating with patients speaking a foreign language and in the use of interpreters. Health care staff need to recognize that social problems might be medicalized, and to develop a deeper understanding of the individual and how to meet individual needs in the light of migrational and cultural background that might influence health.

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