

# Health, Communication and Multicultural Communities



Health, Communication and Multicultural  
Communities:  
Topics on Intercultural Communication  
for Healthcare Professionals

By

Carmen Valero-Garcés

**CAMBRIDGE**  
**SCHOLARS**  

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**P U B L I S H I N G**

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Topics on Intercultural Communication for Healthcare Professionals,  
by Carmen Valero-Garcés

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Dedicated to my parents



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## PREFACE

Communication is an essential component of humans. The published literature also expresses belief in the essential role of communication in patient care. It shows that difficulties in the effective delivery of healthcare can arise from problems in communication between patient and provider rather than from any failing in the technical aspects of medical care and that improvement in provider-patient communication can have beneficial effects on health outcomes. It is within the healthcare sector that a greater number of multicultural encounters occur and where there is a great need for trained staff who can work to avert risk and save time and money while helping to support a right which the Bill of Human Rights recognizes as one to which all human beings should have access. Research related to effective communication in multicultural settings is also becoming increasingly abundant by way of publications, congresses, seminars and activities. Thanks to this increased activity, the topic is rapidly achieving greater recognition and is becoming much more interdisciplinary. This book provides an overview of current issues through a multi-faceted approach, situating the work of potential healthcare professionals and intercultural intermediaries in the broader context of public service providers and practitioners. It also intends to help fill the vacuum in the market of educational materials focused on different language pairs or on those minority languages in which communication is difficult without some sort of third party link. However, this book could not have become a reality without the help of many professionals.

My first thanks go to all those who helped me in this work over the years, especially medical staff, foreign patients, colleagues and students of the postgraduate program in Intercultural Communication, Public Service Interpreting and Translation at the University of Alcalá (Madrid), Spain, who opened up several research paths and contributed with information, experience and data. I have fond memories and great respect for doctors and medical staff of hospitals and healthcare centers in the central area of Spain. Their dedication and respect towards the many foreign patients they had to attend on an everyday basis; often inspiring some of the topics found in this book. The basic research for the original versions of some of the articles in this volume would not have been possible without the contribution of migrant patients. Finally, the production would not have

been possible if were it not for my many years of research on the healthcare setting, the consolidation of the FITISPos group, the contributions of colleagues, the work and effort of students and future public service translators and my own experience coordinating and teaching the Training and Research Program in Public Service Interpreting and Translation at the University of Alcalá, Madrid, Spain as well as at the different associations and organizations in Spain, whose collaboration has been essential to seeing this project to its end. I would like to acknowledge all the Masters and PhD candidates we have worked with over the years, who have contributed to my thinking about the most effective approaches to conducting interdisciplinary research and also lead me and the group FITISPos to identify the need for this book and other publications. I would like to give my most profound thanks to all of them, and especially to Cristina Balaban, Ashley Krewatch and Marianna Musacchio, who contributed with their investigations to develop some of the chapters of this book. I would also like to recognize the diligent work of Amy Tobin and Brian Assaf, who assisted with the translations, revision and copyediting of the book.

I hope that all of the efforts of everybody involved in this book are recognized and followed upon by the readers of these pages. This book in your hands is further proof that we are moving toward multilingual and multicultural societies where languages and cultures are weaving unimaginable webs and where cooperation and interdisciplinary knowledge are more needed than ever before. Interest is growing in many different academic, institutional, professional, and social circles in which we take part. This interest also calls attention to past errors, current needs and the future projects that will be required to solve the difficulties we encounter along the long road toward the consolidation of multilingual communities. Knowledge, research, training, collaboration, and practice are some of the keys to achieving this goal. I truly believe and hope that this book will be helpful in these areas and will be another step towards the successful development of joint actions in the domain of communication in multicultural settings, a field important to those involved in ensuring access to healthcare.

Carmen Valero-Garcés  
Alcalá de Henares, May 2014

# LIST OF TRANSCRIPTION SYMBOLS

*Conventions of Transcription and symbols used :*

[...] = Pause or silence

(;????) = Poor acoustics and what the speaker said was not transcribed

} = overlap

D = Doctor

P = Patient

N = Nurse

## LIST OF ABBREVIATIONS

- ASL (American Sign Language)  
AUSIT (Australian Institute of Interpreters and Translators Incorporated)  
CCHCP (Cross Cultural Health Care Program)  
CHIA (California Healthcare Interpreters Association)  
EFSIL (European Forum of Sign Language Interpreters)  
ESSP (English Speaking Survey Participants)  
FILSE (Federación Española de Interpretes de Lengua de Signos).  
FITISPos (Formación e Investigación en Traducción e Interpretación en los Servicios Públicos/Training and Research in Public Service Translation and Interpreting) group in Spain  
IMIA (International Medical Interpreters Association)  
IoL (Institute of Linguists, United Kingdom)  
LEP (Limited English Proficiency)  
L1 (First Language)  
L2 (Second Language)  
MMIA (Massachusetts Medical Interpreters Association)  
NAATI (National Accreditation Authority for Translators and Interpreters, Australia)  
NCIHC (National Council of Interpreting in Health Care, USA)  
NRPSI (National Register of Public Service Interpreters, UK)  
NSSP (Non-Spanish speaking Patients)  
PSIT (Public Service Interpreting and Translation)  
RID (Registry of Interpreters for the Deaf, EE UU and Canada)  
STK (Small Talk)  
SL (Source Language)  
ST (Source Text)  
TT (Target Text)



# INTRODUCTION

## PATIENT - DOCTOR COMMUNICATION

Communicating in multicultural settings is a field of central interest to those involved in ensuring access to healthcare. Ever increasing migration requires access to essential legal, medical and social services. This book provides an overview of current issues through a multi-faceted approach, situating the work of potential healthcare professionals and intercultural intermediaries in the broader context of public service providers and practitioners.

Extensive research has shown that no matter how knowledgeable the physician might be, if he or she is unable to open an effective channel of communication with the patient, then he or she will likely be of little help to that patient. Asnani (2009: 357- 361) in her article "Patient - physician communication" concludes that, despite this and the fact that a patient-physician consultation is the most widely performed 'procedure' in a physician's professional lifetime, effective communication with the patient has been found to be sadly lacking. If we add the element of 'multilingual and multicultural' to this communication, the situation worsens. This proposal seeks to offer some solutions.

Research related to effective communication in multicultural settings is becoming increasingly abundant by way of publications, congresses, seminars and activities. Thanks to this increased activity, the topic is rapidly achieving greater recognition and is becoming much more interdisciplinary. Faced with the need to respond to the new challenges raised by immigration and the advance towards multicultural societies that has taken place in the last few decades, it has become evident that both healthcare providers and patients must improve their communication in order to avoid misunderstandings and the negative consequences there of. When language and / or culture is an obstacle, new needs and solutions must be developed: Utilizing a third person who knows the languages and cultures involved and thereby can act as a link between provider and patient; training bilinguals to become professional communicators (interpreters, mediators, translators); making resources available in different languages (brochures, dictionaries, etc.); training service

providers to work in multicultural settings; building awareness around the sociocultural differences between communities and how said differences influence communication and daily life; learning how to work with interpreters and / or mediators to name but a few.

Nevertheless, there is scarcely any educational material on the market focused on different language pairs or on those minority languages in which communication is difficult without some sort of third party link. Nor are there specific materials geared at helping service providers or medical staff to understand their customers or patients in the public administration, hospitals, health clinics or schools.

Communication is an important component of patient care. Traditionally, communication in medical school curricula has not existed at all or has been scantily and informally incorporated as part of rounds and faculty feedback. The reliability and consistency of this teaching method leave gaps, which currently receive increased attention from medical schools and accreditation organizations. With the move towards multilingual and multicultural societies, there is also an increased interest in researching patient-doctor communication and recognizing the need to teach and measure this specific clinical skill.

The published literature also expresses belief in the essential role of communication. It shows that difficulties in the effective delivery of health care can arise from problems in communication between patient and provider rather than from any failing in the technical aspects of medical care and that improvement in provider-patient communication can have beneficial effects on health outcomes.

Patient – Physician relationship is also changing. Historically in medicine, there was a paternalistic approach to deciding what should be done for a patient: the physician knew best and the patient accepted the recommendation without question. This era is changing and patients are advising to ask questions and to be informed and to have access to quality information. Patient satisfaction with their care, rests heavily on how successfully this transition is accomplished. A great number of multicultural encounters take place within the healthcare setting and thus, there is a great need for resources such as trained staff who can work to avert risk, and – as research shows- to save time and money.

Most of the working materials and examples are taken from authentic materials. Many of these come from the English-Spanish language pair, since this is a language pair with a dual profile. In the case of English, it is undoubtedly the *lingua franca* in the professional arena, but it is also the linking language in encounters between the dominant and minority communities in immigration settings (e.g between Spanish and Swahili).

In the case of Spanish, it is the third most spoken language in the world, but it is also the minority language spoken among many migrants in a large number of EU countries as well as in the USA, where it represents the dominant minority. In addition, Spain is the EU country which has had the most migration in the last few decades and where the advances towards a multicultural society mean that strategies must be developed to cope with the challenges posed by the new situation.

It is within the healthcare sector that a greater number of multicultural encounters occur and where there is a great need for trained staff who can work to avert risk and save time and money while helping to support a right which the Bill of Human Rights recognizes as one to which all human beings should have access. Thus, even though Spanish and English are used as examples, a lot of the information presented in the book can be extrapolated to other language pairs.

Following there is a chapter breakdown of the contents. Each chapter includes examples and activities that can either be used for self-study or as a textbook to be used in class.

Chapter 1 - Health, Communication and the - Migrant Population. - illustrates certain realities of the communication that takes place between the migrant community and those working in the healthcare sector, especially in those cases where there is no shared language or culture. To begin, I will attempt to define this communication and the agents involved.

Chapter 2 - Communicating in Multilingual Settings. - is devoted to an analysis of the elements which play a role in the chain of linguistic communication, the different types of encounters that occur in medical consults and the problems that arise.

Chapter 3 - Changes in the Healthcare Setting. Perceptions from the Field about the Use of the Language - provides a description of the current state and evolution of health care services in a specific country evolving into multicultural societies where intercultural communication is a necessity.

Chapter 4 - English as a *Lingua Franca*. A Resource for Communication in Multilingual Medical Appointments - is an extension of Chapter 3 inasmuch as it focuses on the use of the English language as a bridge to communicating with non-Spanish-speaking patients in the healthcare clinics and institutions of Spain.

Chapter 5 - Topics: Informed Consent and the Quality of Communication – presents a specific case of communication in doctor-patient consultations: the use of the informed consent with respect to doctor / non-native patient encounters illustrated with questions that arise such as: What happens

when the patient does not “understand” the text? Or, how can one exercise their right to understand and be understood?

Chapter 6 - Negotiation of Meaning in Medical Consultations - focus on providing an analysis of the medical consultation and how meaning is negotiated in this institutional context using a very specific but extremely relevant type of discourse known as *small talk*.

Chapter 7 - Rapport Management Strategies in Intercultural Medical Encounters - might be considered an extension of the study presented in the previous chapter on the use of language in the medical encounter in two types of interactions: health care professional – Spanish patient, and health care professional – foreign patient.

Chapter 8 - Healthcare Providers and Interpreters Working as a Professional Team - help to fill a void which has been the subject of much discussion and the focus of this book: healthcare professional- and communication experts (interpreters and translators) in multilingual settings.

The book is not oriented towards one population in particular, but rather it is directed towards multiple groups, mainly to students of the health sciences and medical staff interested in communicating with the migrants and visitors or those who have to work in multicultural settings.

More specifically, the book is addressed at:

1. Future professionals in the healthcare and medical setting. The goal is to provide them with the theoretical knowledge, skills, competence and tools necessary to communicate effectively in multilingual / multicultural settings.
2. Future linguistic mediators (translating and interpreting professionals). The goal is to provide them with the theoretical knowledge, skills, competence and tools necessary to act as linguistic, communicative and cultural liaisons in the healthcare setting, so they can serve as a bridge between staff and clients who do not know or speak the contact language well.
3. Healthcare and medical professionals who, due to various circumstances, work in a multilingual / multicultural setting and need to strengthen their knowledge in order to communicate effectively.

In a broader sense, the book is directed at:

1. People who have experience as linguistic mediators either through oral or written communication, but who have not received any type of formal instruction.

2. People with experience in translating and interpreting who want to specialize in healthcare.
3. Trainers or developers of educational programs.
4. Those individuals who, for one reason or another, work in multilingual/multicultural settings and need to strengthen their knowledge in order to communicate effectively.

It is not a theoretical book nor is it rule-based by any means. It is a handbook oriented towards reflection and practice born from years of experience training mediators, interpreters and translators working in minority languages within multicultural settings. It can be used for self-study and independent learning, but will also be extremely useful to teachers and trainers of future doctors and medical staff who seek materials or readings for their classes. Furthermore, it will be an excellent resource for mediators, interpreters and translators who want to learn more about communication in healthcare setting.

### **Bibliographic references**

Asnani, MR. "Patient-physician communication". *West Indian Med J.* 2009, Sep; 58 (4), 357-61.

# CHAPTER ONE

## HEALTH, COMMUNICATION AND THE MIGRANT POPULATION

### Key Points

- The migrant population in healthcare settings
- The communication chain
- The migrant community and the Ulysses Syndrome
- Communicative competence and its importance in the therapeutic process

### Key Readings

- Achotegui, J. (2002). *La Depresión en los Inmigrantes: Una Perspectiva Transcultural*. Barcelona: Ediciones Mayo, S.A.
- Clyne, M. (1994). *Inter-cultural Communication at Work: Cultural Values in Discourse*. Cambridge: Cambridge University Press.
- Gumperz, J. (1982). *Discourse Strategies*. Cambridge: Cambridge University Press.
- Poyatos, F. (1993). *Paralanguage: A Linguistic and Interdisciplinary Approach to Interactive Speech and Sounds*. Amsterdam/Philadelphia: John Benjamins.

### **1.1 Introduction. The migrant population and communication in healthcare settings**

The primary goal of this chapter is to illustrate certain realities of the communication that takes place between the migrant community and those working in the healthcare sector, especially in those cases where there is no language or culture in common. To begin, I will attempt to define this communication and the agents involved; I will then contextualize the phenomenon of migration as it affects healthcare, given the fact that this is

one of the most important sectors in countries such as Spain. I will be using Spain as an example and will be analyzing its characteristics and needs. Further along I will discuss another key agent in this communication: the healthcare worker. I will likewise analyze his or her characteristics and the difficulties he or she faces, paying special attention to the two groups which provide care to the greatest volume of migrants and visitors; primary care providers and nursing staff. This will lead us into a brief discussion of transcultural medicine and nursing and I will conclude by providing some key recommendations for the future in light of the challenges posed by the 21<sup>st</sup> century.

## 1.2 Communicating with the migrant community

The characteristics of the migrant patients that typically go to healthcare clinics and hospitals are without a doubt expressed in the profile which Carballo (2006) sets out and which is illustrated in the table below (Box 1.1.):

### Box 1.1.

<b>Some Characteristics of the Migrant Population</b>	
-	Alienation and chronic sadness
-	A more stressful experience depending on gender
-	Rarely with family
-	Economic insecurity
-	Legal insecurity
-	Difficulties with the language
-	Difficulties with the culture
-	Difficulties with the social environment
-	Social and political-legal rejection

However, as Martincano (2003) reminds us, we are prevented from assigning any one homogeneous classification to all migrants given the diversity in life cycles. In other words, as people migrate to a country, they modify, acquire and adopt changes to their personal and social patterns of behavior, including those which impact their health (reproductive health, mental health, contagious diseases, occupational health...). Nevertheless, these people bring with them languages and cultures that are far-removed from the majority culture. This will inevitably lead to friction and will require both parties to make an effort to get along.

Based on this situation, it stands to reason that difficulties will also arise in the doctor-patient relationship, which may prevent the migrant patient from (fully) accessing the healthcare system for different reasons: a limited to total lack of knowledge of the official language, different opinions regarding health, illness or pain, lack of knowledge about how the country's healthcare system operates or about healthcare policy.

More than a decade ago Talero Martín (1997) described the main barriers that a patient comes up against when trying to access health care in Spain. These barriers can be classified into three groups: those stemming from the health care system, those related to the patient himself and those which are dependent on the health care professional. They are illustrated below in Box 1.2.:

### Box 1.2.

<b>Barriers in the Health Care Process</b>		
<b><i>Stemming from System</i></b>	<b><i>Dependent on healthcare professional</i></b>	<b><i>Related to patient</i></b>
<ul style="list-style-type: none"> <li>- Inadequate accessibility</li> <li>- Excessive wait time</li> <li>- Excessive demand/too little time for appointment</li> <li>- Noise and interruptions</li> <li>- Excessive beaurocracy</li> </ul>	<ul style="list-style-type: none"> <li>- Dysfunctional personality for clinic</li> <li>- Professional in charge of evaluation, or consult</li> <li>- Projects too much onto patient</li> <li>- Exhibits excessive control</li> <li>- Shows low empathy</li> <li>- Emotional interference</li> <li>- Issues related with the job itself</li> <li>- Problems in professional's personal life</li> <li>- Lack of training in communication skills</li> <li>- Lack of training in mental health issues</li> <li>- Social interference</li> </ul>	<ul style="list-style-type: none"> <li>- Physical problems: aphasia, hearing loss...</li> <li>- Emotions at breaking point: anxiety, aggressiveness...</li> <li>- Abnormal personalities: overly-dependant, obsessive</li> <li>- Somatoform disorders</li> <li>- Non-compliant patients</li> <li>- Frequency of visits</li> <li>- Language barriers</li> <li>- Social interference: Sociocultural distance.</li> </ul>

Based on Martín Talero's profile, we can conclude that the healthcare system is complicated, extremely bureaucratic and totally inaccessible for anyone unfamiliar with how it operates in Spain (i.e. prescheduled appointments, long lines, infinite service windows, etc.) or who do not speak the official language.

According to Martincano (2003), the situation in terms of accessing the health care system underwent very little change in the first decade of the 21st century. This is illustrated below in Box 1.3.:

### Box 1.3.

<b>Issues with Migrant Access to the National Healthcare System (Spanish acronym - SNS)</b>
<ul style="list-style-type: none"> <li>- Active abandonment</li> <li>- Lack of knowledge</li> <li>- Bureaucratic complexity</li> <li>- Obstacles posed by local authorities</li> <li>- Difficulties with language</li> <li>- Cultural and religious questions</li> <li>- Social and labor difficulties</li> </ul>

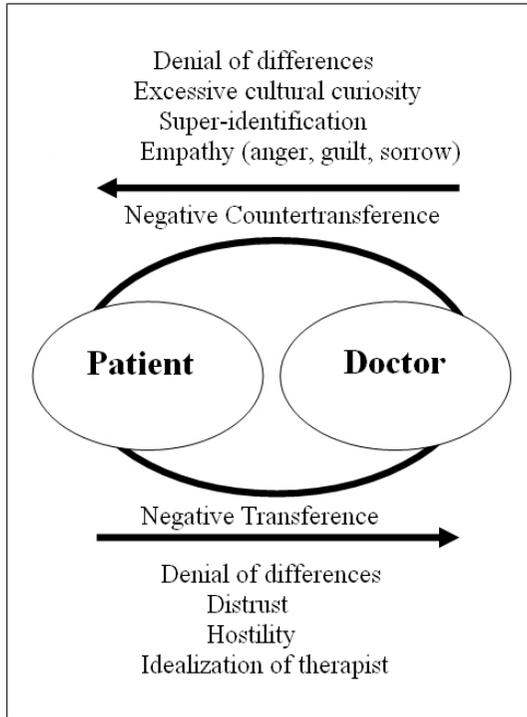
An important factor that can affect the quality of healthcare is the degree of empathy and how it is expressed or what we might call "social interference on the part of the professional". This social interference can stir up a variety of emotions, as shown in Box 1.4.:

### Box 1.4.

<b>Social Interference from Professional</b>		
Ethnocentrism	Prejudice	Agression
Xenophobia	Stereotypes	Abusive behavior
Segregation	Discrimination	Exclusion
Racism	Hate	Social Exclusion
New racism	Rejection	Legal Exclusion
Ethnosensitivity	Information Have-nots	Exclusion from information
	Recognize and appreciate differences	

These emotions tend to come to the surface especially when a medical provider's work with the patient stirs up unresolved feelings of oppression and prejudice within him. This is due to the phenomenon of transference and countertransference that occurs within the doctor-patient relationship.

The outcome will depend on the direction of these emotions and the provider's attitudes towards the migrant patient. This is explained in more detail in the following chart (Figure 1.1) (Martincano 2003):



**Figure 1.1: Providers' attitudes**

The outcome also has to do with the tendency to apply the traditional model of western medicine. This model is characterized by medical paternalism and the doctor's role as part of a professional and social group which assumes the responsibility for healthcare. It is rooted in ethnocentrism and not in cultural relativism. Were the latter applied, it would allow for more flexibility and curiosity, as well as the desire to recognize and explore the intercultural components of the patient's feelings, show respect for other cultures and take a more sensitive approach to other customs.

### 1.3 The Ulysses Syndrome

Mental health of the migrant patient is also a key element in the provision of primary care, owing to the enormous influence that migration can have on the mental health of a patient. López Izquierdo, Martín del Barco and Álvarez (2007: 3 (5): 259-266) believe there are a number of factors that can make the migrant's experience so stressful: leaving behind family and one's homeland, the break with one's culture and customs, having to face a new society, experiencing difficult situations (unemployment, marginalization, discrimination), or the need to adapt to changes that lead to an imbalance between the demands of one's environment and one's ability to meet these demands and changes to which he/she is subjected.

This phenomenon is known as migratory grief and it involves the development of certain defense mechanisms that are expressed as: denial, projection (rejection, xenophobia), idealization and rationalization. When these mechanisms fail, the migrant may begin to suffer from depression and anxiety disorders, and then, he/she may develop the Immigrant Syndrome with Chronic and Multiple Stress, or Ulysses Syndrome (Achotegui 2002).

Described for the first time in 2002 by psychiatrist Joseba Achotegui from the Universitat de Barcelona, the Ulysses Syndrome refers to a set of symptoms experienced by people who leave their countries of origin to settle in an unknown land. The name of the syndrome is taken from the legendary Greek king of Ithaca depicted in Homer's poem, the *Odyssey*. This epic tale describes Ulysses' 10 years of struggles as he tries to return home after the war and claim his rightful place as the king of Ithaca.

The Ulysses Syndrome potentially affects anyone who migrates to a new country and faces the chronic stress that typically comes with adaptation to a different culture. It includes both physical and psychological symptoms, such as those of depression and anxiety, as well as somatic and dissociative symptoms ranging from headaches to clinical depression.

Martincano (2001) defines this as a specific disease linked to the intense nature of the chronic stress brought on by solitude, the battle for survival, frustration and the sense of failure felt by migrants. It is characterized by the presence of countless external stress factors of extreme intensity. This syndrome can be chronic, lasting for months or years. Figure 1.2 shows a summary of the stress factors involved in the psychopathological development of the migrant patient:



**Figure 1.2: Stress factors**

Following Achotegui (2002), the main stressors which cause this syndrome are:

- 1) Loneliness, especially present when the newcomer has left children and spouse behind. The overwhelming majority of migrants quickly realize how painful that first stage in the process of integration to a new country is, a process that starts with mourning all they have left behind.
- 2) Sense of despair and failure. Very often the migrant invests everything he or she had only to find that they cannot find the conditions to make even a decent living or fulfill their professional goals in the new country.

- 3) Survival struggles. Instead of fulfilling the dream of improved quality of life and being able to save enough money to send home or to provide a “better future” to their offspring, migrants often find themselves hardly making ends meet. People suffering from Ulysses Syndrome experience fear because of the uncertain future, and the struggle to survive overshadows all other priorities.
- 4) The risks endured in the process of migrating and settling down.

As for its treatment, recognizing the advances of the International Psychiatric research in demonstrating varying degrees of efficacy for improving and managing most advanced mental disorders through either psychotherapy (including talk therapy) and the use of medication (antidepressant, tranquilizers, stimulants, and a wide range of anti-psychotics), Diaz et al (2013) criticize the treatment frequently given for the Ulysses syndrome, which consists of simply increasing the prescription dose of this sort of medication. The example that follows illustrates their comments:

#### **Box 1.5.**

The case of Teresa, a migrant girl from Central America, who is one of many of newly arrived migrants experiencing the Ulysses Syndrome, including sadness, migraines, fatigue and bone pains. Teresa was seen by her general and primary physician who without providing her with any form of health education in Spanish, her native language (e.g., brochure, flyer, booklet or basic information), proceeded to prescribe her Prozac, a medication used by adults for the treatment of major depressive disorder, panic disorder, obsessive-compulsive disorder, and treatment-resistant depression. The medication did not alleviate Teresa’s symptoms of sadness (i.e., homesickness). Rather, it worsened the initial condition and induced undesirable side effects, including lack of coordination, increased anxiety, impulsive and dangerous behavior, and thoughts about suicide. Her case illustrates how physicians often over prescribe medication, and minimize the evidence of dependency and adverse secondary drug reactions, especially to migrants of different cultural backgrounds experiencing extreme levels of stress. (Diaz et al. *The Ulysses Syndrome: Migrants with Chronic and Multiple Stress Symptoms and the Role of Indigenous Linguistically and Culturally Competent Community Health Workers*. 2013:4)

According to these authors, “the extensive therapeutic use of stimulants and a large number of psychoactive drugs in the cases of the many migrants with chronic and multiple stress syndrome, represents not only the ethnocentric medical approach in the west as the only valid and scientifically objective approach, but also a means of unjust social control of this population”. As globalization continues to permeate all social layers, this point of view is being increasingly supported by researchers and practitioners. As Diaz et al state, the diagnosis of depression is an easy way out and fits into a particular Western medical and cultural model, which reduces the psycho-social problem of an individual who in the diagnosis, is abstracted from a socioeconomic content and then held solely responsible for his / her mental well being.

Going against this tendency and in line with Achotegui’s studies, they propose a sociocultural approach rooted in a well designed and a well monitored community-based program as a means to identify and help migrants experiencing the Ulysses Syndrome.

To summarize, the inability to communicate due to the language barrier is a factor that must be taken into account, given that it can lead to different kinds of health-related complications for the migrant patient that can manifest as the condition known as Ulysses syndrome. This is a condition suffered by those who miss their homes, family and culture, which they have been forced to leave behind due to professional or personal circumstances, and who are unable to find a place in society. This inability to find one’s place in society is very much linked to the inability to communicate within one’s surroundings due to language.

## **1.4 Communicative competence beyond the words**

Migration is, thus, an important life event which is influenced by many factors and which can have diverse consequences, one of which is without a doubt the consequence on health. It is a change which typically prompts other important life events (loss of or being uprooted from one’s family, language, customs, land, religion, culture, physical safety, economic changes, social activities, type of work, etc.) which can all affect the person’s health. As a consequence, doctor’s offices – especially in the primary care setting – are full of migrant patients with health problems who bring with them different practices and beliefs around health, the way a person becomes sick or is cured of illness.

These new patients therefore create new needs which must then be met. The first step must be achieving awareness of this new reality. My focus will be on one of the many elements of this reality: communication