

Case Report

Inequalities Limiting Health Care Access for Migrant Australians – The Positive Impact of Multiculturalism and Medical Student Rotation to Remote Hospital Settings

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Abstract

Limited access to public health insurance may negatively impact patient care for migrant Australians particularly those in remote hospital settings. This may reflect language and other social barriers including not insignificantly, apprehension of cost and fear of subsequent reprisal. This case reports the experience of a 26-year-old Malaysian female who presented to an emergency department with suspicion of ectopic pregnancy.

Background: Globally, Australia is a major immigration target. Population data from 2020 estimate over 7.6 million migrants currently living within our borders, with many in regional or remote rural centres [1]. Access to effective healthcare is often impacted by demographic and social challenges unique to this population which include affordability and economic limitations, cultural bias and vulnerability, language barriers and alienation from the Australian Medicare system [2]. The latter, a Commonwealth government program, provides Australian citizens and selected temporary visa holders, access to a wide range of health services including hospital and outpatient treatment, pharmaceuticals and diagnostic services without cost or with subsidy by way of the Medical Benefits Schedule [3]. Patients not able to share in this scheme, may be left isolated or unfairly biased when issues of health crisis or routine self-assessment arise.

We present a case report of a 26-year-old female migrant of Malaysian origin, who presented acutely to a public hospital emergency department with suspected acute abdomen. She had limited understanding of English and had no Medicare entitlement. Whilst we were able to provide care for this young woman, our ability to do so was significantly hindered by these barriers, a dilemma not uncommon in remote rural practice. It highlights the inequalities of a healthcare system that at times can have little reserve or capacity to encompass the needs of patients with cultural or social demographics that may segregate or displace them from the general population. This is all the more poignant when it occurs in a setting of limited resource and vulnerability and it demonstrates the importance of shared language skills, compliance, and a culturally sensitive and inclusive healthcare environment.

Keywords: Medical Students; Migrants; Medicare; Multiculturalism; Remote Practice; Displacement

Case Presentation

A 26-year-old Malaysian female gravida 1 para 0 presented late in the evening to the emergency department of a remote public hospital with acute abdomen in the setting of recent onset vaginal bleeding and positive urinary pregnancy test. The patient had no Medicare entitlements and was reluctant to engage with medical services, including permission for Ultrasound for fear of cost. Fortunately, she subsequently agreed and examination was performed suggesting high likelihood of ruptured ectopic pregnancy. Gestational age was estimated to be 9 weeks based on last reported menstrual period. The patient was a migrant Australian with unknown visa status who spoke native Mandarin with very limited understanding of English. Adding to this, the patient presented alone, with no immediate social

or family support other than a friend who could be reached by phone.

On arrival to the emergency department, the patient was fretful but clinically stable. She had a moderate tachycardia of 105bpm, with all other observations in normal range. Clinical examination revealed a slightly distended abdomen with mild voluntary guarding of the lower quadrants. A more detailed history was not possible, and despite support from phone interpreter services, the patient was unable to fully understand the implications of her diagnosis. She was apprehensive, knowing that something was happening to her, but she was reluctant to commit to recommended care. We were however, able to establish intravenous lines and to take bloods for urgent quantitative beta-hCG, full blood count, group and cross matching.

At this time, preferential diagnosis aligned with USS prediction

of a ruptured ectopic pregnancy. This was based on the combined findings of an empty uterus and significant free fluid suggestive of intra-abdominal bleeding. Differential diagnosis included haemorrhagic corpus luteal cyst or some other non-pregnancy related intra-abdominal bleed. The primary intent of the treating team was to proceed towards diagnostic laparoscopy. They were however, unable to effectively communicate this to the patient who remained anxious and reticent to commit to any immediate action, particularly the prospect of surgery, for fear of cost. Unable to bridge this divide, the treating team conceded to manage the patient expectantly. There was reluctance to do so for fear of missing a critical diagnosis, however they were buoyed by the stability of repeated clinical observation which showed no evidence of deterioration. The patient was thus managed conservatively with the recommendation to re-consider if change arose.

The patient was reviewed the following morning. On this occasion, the clinical team included a medical student who spoke fluent Mandarin and was on current rotation to the Obstetrics & Gynecology department. They were thus able to share face to face communication with the patient which allowed a personalized explanation of the suspected diagnosis and the potential complications. With reassurance of care, and mitigation of fear including concerns of financial ramification, the patient agreed to proceed with recommended care. She was taken to theatre and underwent examination under anesthesia and diagnostic laparoscopy. Unexpectedly, there was no sign of free bleeding or an underlying ectopic pregnancy. She had a large, fluid filled 20cm right ovarian cyst which extended across the midline from the ovarian fossa to the posterior pelvic wall up to the level of lumbosacral junction. The cyst wall was intact with normal perfusion and no evidence of torsion or obvious injury upon adnexal structures. No further surgical action was taken. Prior to the procedure, repeat serum hCG had fallen significantly which, together with the newly appraised clinical findings, was consistent with a likely miscarriage and so a dilatation and curettage was performed with tissue samples sent for histopathology.

Following surgery, the treatment team had face to face discussion with the radiology department to convey the outcome and review the initial films in the light of known findings. While it was conceded that the free fluid was cystic, the initial presumption of diagnosis was still considered valid. Follow-up investigation by chest, pelvic and abdominal CT was arranged and serum tumour markers including ca-125, ca19-9, alpha-fetoprotein, lactate dehydrogenase and repeat beta-hCG were collected. The findings and recommendations were discussed with the patient post-operatively, again utilizing the linguistic support of the medical student to allow detailed explanation of the findings and their implications. Importantly, they were able to do so in manner that was timely, that was emotionally supportive and responsive to the personal needs of the patient as they arose. This nurtured a feeling of continued safety and trust which were indelible to the success of her immediate and eventual, long-term recovery.

Subsequently, histopathology reported decidualized endometrium without trophoblast. Serum hCG continued to fall in keeping with the diagnosis of an early failed pregnancy. Tumor markers were negative, indicating benign pathology and the CT was consistent with a large ovarian dermoid cyst. The patient subsequently declined any further

surgical intervention because of financial concerns and shared that she intended to return home for definitive care.

Discussion

Australian migrants are often poorly recognized by health care services and thus may suffer risk of major disparity in access to appropriate support in the event of existent or emergent need. For these and other reasons, which include pre-existent morbidity, lifestyle hardships, working austerities and financial constraint, they are often disproportionately vulnerable to poor health management outcomes, particularly when amplified by the isolation of rural setting and the limitations of scarce resource and provider availability. Add on to this, the restrictions of current legislative policy and the restrictive regulations surrounding health care entitlement for Australian immigrants and we see situations such as this that arose for our young patient [5]. Regrettably, this is not an isolated example, with very few temporary resident migrants eligible for Medicare entitlements meaning that many are unable to access the benefits of comprehensive health assessment, outpatient and intervention programs, Medicare, healthcare subsidy card and counseling [3,6]. In essence, they are abandoned. Unable to reach out for help and sadly, too afraid to accept it.

The percentage of none or poorly speaking English migrants to Australia has risen in recent years to nearly 60% of all applicants [7]. As our case report shows, no matter how much we might try to bridge this gap in clinical practice, whether through community programs or the provision of as-required interpretive services, large holes remain, leading either to a disinclination to receive care or to a disruption to the continuity and compliance with that which could otherwise be provided [8].

One can easily understand why health outcomes and states of general health wellbeing tend to be poorer in this population compared to their English-speaking cohorts. These may be compounded by increased source of error within the treatment environment exacerbated by lack of trusted, timely communication leading to misunderstandings of medication and prescription, compliance with management plans, fear of the unknown and displacement from family support. There is stress for the patient, their support persons and family, and for the care givers who find themselves in a position of risk and helplessness [8]. All of these issues can be cumulative as indeed occurred in our case presentation. Though we had access to a phone line interpreter service, we were still unable to communicate effectively to develop a shared understanding of management decisions sufficient to allow compliance [9,10]. In our example, this was exacerbated by the patient's social circumstances which left her with no immediate family support. She was in a remote hospital setting at a time of continued COVID restriction which would normally mean there is little opportunity to access culturally sensitive services to support medical care. Fortunately, however, we had in our team a young medical student of similar ethnicity who was able to communicate face-to-face with the patient in her own native language. This, when shared with genuine compassion and empathy, allowed diminution of her anxiety and the forging of trust and compliance which allowed us to move forwards with proposed treatment.

This case, demonstrates the impact of barriers and bias, language and otherwise. It shows how ingrained they can be in Australian community and how recalcitrant they can become in developing true compliance. It highlights the value of native-language communication for the patient to resolve fear and hesitation and to support emotional wellbeing and eventual healing. In our case, a medical student was able to bridge that gap. She was able to listen, to encourage the patient to speak, and to convey the recommendations of medical management to the patient in her native tongue. The effect of this rapport was immediate. We saw the patient relax, her fear abated and her demeanour became one of trust and acceptance. We were able to proceed with our recommended action and to provide best possible treatment. Post-operatively, the patient continued to feel supported in an environment of safe reassurance and she was able to remain engaged in decision making, asking questions and actively participating in the shaping of heron going treatment process. This was invaluable to clinical outcome.

Patients estranged from normal society, whether by language or other social and demographic isolates, are vulnerable to misunderstanding and therefore misapprehension of medical care. This is particularly true of non-English speaking migrants in remote areas of rural Australia. They are often without significant financial support and find themselves unable to access government funded assistance to resource opportunities for care that most of us take for granted.

It is beyond the scope of an individual report to action significant change or to correct the paucities of resource and provision that will no doubt continue to abide and disadvantage many in our community, but we can advocate for better understanding in ourselves and to recognize that the time taken to approach care compassionately and with empathy is a resource never limited, if we choose to guard it well. We can also look ahead with optimism for just as the problems we encountered may arise through discriminations engendered by ethnicity, the multiplicity and diversity of our culture means that we may very well have team members and colleagues amongst us who are able to bridge many of these gaps. This was so in our case. We can also take great hope that for the medical student involved, an opportunity to practice real and valuable patient centered care arose and that she was able to create a difference simply by her commitment as a young doctor to work in rural practice. This reminds us as supervisors and training mentors to be inclusive and to actively encourage the participation of nursing and medical students who might otherwise be disregarded or be seen as just another tag-along to teach, a burden or a nuisance that keeps us from getting to the lunch room on time [11,12]. The case demonstrates an often less than valued asset that medical students bring to collaborative and multidisciplinary care and of equal import, to the long-term enrichment of career, that permission to help and participate can bring. Contemporary medicine is underpinned by the success of team work, and this requires inclusion, this means everyone, the care givers, the patient, and the often much maligned presence, of our junior training team.

Conclusion

Access to public health services is a right that most Australians take for granted. Sadly, this privilege is not shared by all. Migrant Australians are often marginalized by limited access to services, whether by geographical isolation where provision is affected by scarcity or by other social barriers including language and financial support that may encumber individual liberty or empowerment to integrate successfully. This case report demonstrates one such example. Whilst it highlights the difficulties of isolation, and the importance of individualized consent, it also identifies the resources that we have within our existing service, that when recognized, may often yield unexpected solutions. In so doing, we re-state the importance of multiculturalism within our team structure and the positive benefit of broad inclusion, whether that be of medical students or any other element of the treatment team, to provide a responsive, patient centered focus of care.

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