

Medical Encounters in Finnish Reception Centres: Asylum-Seeker and Clinician Perspectives

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Refugee health often is shaped by interactions with clinicians in care settings that lack ethnocultural match. The article analyses intersubjective perspectives concerning key aspects of 41 ethnoculturally discordant medical encounters involving asylum seekers, mainly from the former Soviet Union, the former Yugoslavia, Kurdish areas in the Middle East, and Somalia, resident during summer 2002 in five Finnish reception centres. Attaining congruent perspectives is an important challenge in transnational encounters involving clinicians and displaced persons. The healthcare perspectives of asylum seekers and their attending Finnish physicians showed little correspondence. Transnational competence (TC) offers an innovative comprehensive framework for assessing and addressing ethnoculturally discordant healthcare encounters. In this study, we most frequently encountered congruent perspectives regarding health status at the time of arrival, illness explanations, utilization of ethnocultural healthcare practices, and perceptions regarding the presence of mental health problems, depression, and place-of-origin contributors among patients attended by high-TC physicians. The findings also suggest that the TC of all medical-encounter participants makes a difference in terms of asylum seekers' satisfaction with medical encounters, confidence in the future value of the attending physician's recommendations, and perceived healthcare effectiveness in their new surroundings—perspectives with the potential to exert a positive impact on health outcomes for forced migrants and receiving societies.

Introduction

The most likely population scenario for the twenty-first century involves 'more people, more population movements, more displacement—both internally and internationally—and more demands for effective responses by relevant authorities' (Helton 2002: 14). If past experience prevails, we can expect forthcoming migrations to be associated with elevated levels of morbidity and mortality among those who move and among receiving populations (Curtin 2002).

The interdependent claims of refugee and societal health and well-being that arise from forced population movements are played out in transnational interactions among clinicians and people in spatial transition with diverse

backgrounds who present in healthcare settings that do not allow ethnic match (Koehn 2004: 70). While largely unstudied, today's transnational health-consultation encounters are generating common challenges and opportunities for problem-solving partnerships around the world (Kickbusch and Buse 2001: 729). Western clinicians encounter forced-migration patients from non-Western countries at home (e.g., in resettlement centres) and abroad (e.g., in refugee camps—see van Selm 2003: 85). When local or regional medical personnel are available, medical consultations with refugees and the internally displaced in the South also frequently involve cross-nationality, cross-ethnicity, and/or cross-cultural interactions.

Increasingly, therefore, ethnically discordant physicians consult with patients who come from a multiplicity of places and do not conform to uniform sets of cultural orientations and practices. In multinational clinical settings, interpersonal *transnational competence* (TC), a specific set of skills based on research findings in development studies, international business negotiations, cross-cultural psychology, and intercultural communication, promises to be particularly useful. In comparison with the emphasis of cultural competence on standardized two-culture interactions (Shapiro and Lenahan 1996: 249; Wear 2003: 550–551), TC offers a more comprehensive approach for today's fluid and diverse multicultural medical encounters. The TC framework treats case-relevant knowledge acquisition, perceptual sensitivity, creative partnering, communicative facility, and effective functional behaviour as interdependent, context-specific, and ongoing (see Tervalon and Murray-Garcia 1998: 118) individual skill-based challenges (see Koehn 2004; also see Koehn and Rosenau 2002). In 2004/2005, four US medical schools initiated the process of introducing a TC curriculum by piloting changes in clinical clerkships that are aimed at enhancing physicians' transnational analytic, emotional, and functional competence (further information available from the author).

In analysing the potential contribution of transnational competence in ethnoculturally diverse medical encounters involving forced migrants and healthcare professionals, the research focus of this project is on intersubjective perspectives. The internal self-perceptions and narratives of patients (see Ware *et al.* 1995: 539, 555; Roter and Hall 1992: 8–9, 133; Popay and Williams 1996: 760–761) and the external subjective evaluations of care receivers by attending professionals are critically important in assessing health and illness (see Sen 2001: 70; Matinheikki-Kokko 1997: 17–18). In this study, the perspectives of all participants in the clinical consultation are acknowledged to possess advantages and limitations (see Sen 2001: 70; Cardarelli *et al.* 2003: 179–180) and neither the perspective of the care provider nor the perspective of the patient is privileged. By respecting patients and their healthcare providers as mutually dependent (Pappas 1990: 200–201) participants in a therapeutic relationship, avoiding 'uncritical acceptance of medical perspectives' (Gochman 1997b: 414; also see van Ryn and Burke 2001: 813–814, 822), and locating 'points of cultural dissonance or synergy' (Tervalon 2003: 571), this approach opens up possibilities for care receivers—in this case, asylum seekers—to 'inform healthcare practice and research with the

unconventional perspectives needed to alleviate suffering among refugees' (Muecke 1992: 521).

The 'centrality of patient voice' (Roter *et al.* 2001: 84; Smedley *et al.* 2003: 12, 237) demands that healthcare studies incorporate refugee perspectives. When refugee perspectives on personal health and illness are withheld from, and/or incongruent with the perceptions of, host clinicians, their healthcare needs cannot be addressed fully and effectively (see Tiilikainen 2001: 312). When the insights, needs, and signals of care seekers are missed and/or dismissed by providers, and expectations are mismatched, individual and community health are likely to suffer (see, for instance, Ma 1999: 422; Smedley *et al.* 2003: 9). For refugees accessing Western biomedical treatment systems, the potential consequences of incongruent perspectives regarding health and illness include misdiagnosis and misuse of interventions (Brach and Fraser 2000: 182), under-diagnosis and under-utilization of available treatments, therapies, and other health services with the potential to produce a favourable outcome (see Smedley *et al.* 2003: 1, 5, 30, 77–79, 239; van Ryn and Burke 2001; Fox 2000: 31), and overdiagnosis or 'medicalization' (Walker 1994: 10). Overdiagnosis can stem from reliance upon cultural generalizations and racial/nationality stereotyping as well from the application to care receivers of physician understanding of epidemiologic evidence regarding population-based probabilities 'regardless of actual individual [patient] characteristics' (van Ryn and Burke 2001: 822–823).¹ To the extent that overdiagnosis portrays mobile populations in a sick role, it serves to 'pathologize' the asylum-seeker's experience (Ager 1999: 13; Harrell-Bond 1999: 152–153; Derges and Henderson 2003: 87) and to perpetuate 'popular explanations in the receiving society' of migrant social marginality (Eastmond 1998: 177). In contrast, congruent assessment perspectives empower clinicians to offer medical advice that is consistent with their patient's beliefs, values, and lifestyle and to enhance opportunities for forced migrants to enjoy 'the freedom to achieve good health' and quality of life in the host society (Sen 2001: 72).

Can transnational competence in ethnoculturally discordant consultations make a difference in fostering the corresponding assessment perspectives that promote refugee health and well-being? In this article, we first explore the extent of patient/clinician congruence on vital healthcare-related dimensions in interactions that lacked ethnocultural match. Then, we test the argument that the TC demonstrated by participants in consultations concerning the health of arriving asylum seekers (ASY) is related to congruent perspectives and to positive outcome assessments.

Study Objectives, Methods, and Participants

Medical interviews constitute one of the primary reception processes experienced by applicants for formal resettlement in a new land. The analysis presented in this article is based on perspectives regarding transnational medical encounters drawn from 118 interviews conducted during summer 2002 with

political-asylum seekers and their ethnoculturally discordant clinicians at five reception centres spread across the southern tier of Finland: Kontiolahti, Joutseno, Kotka, Helsinki, and Turku. Municipal communes operated nine of Finland's 16 reception centres in 2002, including Kotka, Kontiolahti, and Helsinki. The state operated three centres (including Joutseno) and the Red Cross was responsible for the other four (including Turku). Political-asylum seekers at Finnish reception centres range from persons who have just arrived to those who have been awaiting a decision on their request for more than three years.

The researcher randomly selected asylum seekers from nationality-based 'blind' lists of current adult residents who had clinically presented. Reception-centre staff prepared and enumerated the lists, provided each selected ASY with a brief explanation of the study, and inquired about his/her willingness to participate. Their lists were 'blind' in the sense that they provided the researcher with the names of only the selected adults who had agreed to take part in the interview. In total, we interviewed 41 asylum seekers. The study participants included 11 Kurds from Iran, Iraq, and Turkey (31 per cent of the total number of Kurdish adults residing at the five selected reception centres at the time of the study); 12 Albanians, mainly from Kosovo (30 per cent); 13 asylum seekers (18 per cent) from the former Soviet Union—including Russia, Ukraine, Chechnya, Uzbekistan, and Armenia—and 3 Somalis (60 per cent). We also interviewed the only asylum seeker from Bosnia resident in one reception centre and the only Angolan at another. Centre staff reported only one Kurdish speaker and one Albanian who declined to be interviewed. We identified and incorporated the patient's principal attending physician and health-support professional (nurse, social worker); we excluded any 'secondary' clinicians who had not consulted as frequently with the patient. All of the primary physicians and support professionals (SPs) attending to asylum seekers agreed to participate in the study. However, only 36 of the selected asylum seekers had seen a doctor at the time of the study. All had seen a nurse.

The ground-breaking nature of TC research required the development of a research instrument that elicited each interviewee's subjective evaluations regarding the encounter behaviours of all primary participants (including her/himself) in the clinical consultation(s). Independent and privately conducted interviews utilized a mostly close-ended, pilot-tested questionnaire designed to elicit basic demographic and social-background data and intersubjective perspectives on health-related matters from the patient (asylum seeker), his/her doctor, and/or his/her support professional (most commonly, nurse). In the interview, which typically ranged from 45 to 90 minutes in duration, each study participant responded to questions related to his/her social background, the patient's state of physical and mental health, the patient's health consultations with his/her principal attending physician and support professional, and the healthcare and medical-encounter behaviour and abilities of patient, doctor, and nurse (or other SP). Each participant reported regarding perceived health outcomes (e.g., patient satisfaction with the results of the healthcare provided by the

principal attending physician) using a uniform five-point Likert-type response continuum.

In all cases, interviewers secured prior verbal consent to conduct the interview. We promised study participants that their names would never be used, that the interviewer and any interpreter would respect their confidentiality and not divulge their responses, and that all project data would be coded and only reported in a statistical and anonymous manner. The principal investigator explained to all ASY that their answers would have no effect on their access to services or on the outcome of their asylum application, described his general plan for disseminating project findings among participating migrant communities and Finnish healthcare professionals, and noted his intention to contribute to improving migrant healthcare generally through policy and training recommendations based on study findings.

The principal researcher interviewed 13 ASY (32 per cent of the total) in English. In his presence, fluent English-speaking interpreters conducted 9 asylum-seeker interviews in Russian (22 per cent), 8 in a Kurdish dialect (20 per cent), 6 in Albanian (14 per cent), 2 in Somali (4.9 per cent), 2 in Turkish (4.9 per cent), and 1 in German (2.4 per cent). The principal investigator conducted 29 of the physician interviews (80.6 per cent) and all of the support-professional interviews in English. Project assistants conducted the other 7 physician interviews in Finnish.

Table 1 presents the principal characteristics of the total sampled population along with a gender breakdown. Both recent arrivals and long-term ASY are represented in the sample. Just over half (51 per cent) of the sampled patients had been in Finland for a year or less, including 12 per cent who had arrived within the past six months. Twelve interviewees (29 per cent) had been awaiting a decision on their asylum application for more than two years.

Males constituted a majority (59 per cent) of the interviewed asylum seekers. However, female physicians attended to 89 per cent of the interviewees (all of the female patients) and female nurses worked with 83 per cent of them (88 per cent of the male patients). All of the doctors and support professionals were Finnish. There were no ethnic/nationality matches among care providers and receivers.

Centre medical records showed only one patient/physician encounter for 23 per cent of the interviewed asylum seekers who had seen a doctor. There were two or three consultations with the interviewed physician among 29 per cent of the interviewed patients. About half (49 per cent) of all ASY (more than two-thirds of the females) had met with the attending physician participating in the study on four or more separate occasions, including 17 per cent with between 10 and 30 medical consultations. Resettlement-centre residents receive healthcare and advice more frequently from support professionals than they do from physicians. Among those interviewed, only 3 asylum seekers (7 per cent) had held a single medical consultation with a nurse or social worker at the time of the interview and only 6 males (15 per cent) were limited to two or three interactions. There were 13 cases (32 per cent) where interviewed patients had interacted with

Table 1

Sample Characteristics						
Attributes/Experiences	Male asylum seekers		Female asylum seekers		Total	
	#	%	#	%	#	%
<i>Duration stay in Finland</i>						
1 year or less	14	58.4	7	41.2	21	51.2
>1–2 years	5	20.8	3	17.6	8	19.5
>2 years	5	20.8	7	41.2	12	29.3
<i>Attending physician's gender</i>						
Male (Finnish)	4	21.1	0	–	4	11.4
Female (Finnish)	15	78.9	16	100.0	31	88.6
<i>Attending support professional's gender</i>						
Male (Finnish)	3	12.5	4	23.5	7	17.1
Female (Finnish)	21	87.5	13	76.5	34	82.9
<i>Consultations patient/ principal doctor</i>						
1	4	26.3	3	18.8	8	22.9
2–3	8	42.1	2	12.5	10	28.6
4–8	5	26.3	6	37.5	11	31.4
10–30	1	5.3	5	31.3	6	17.1
<i>Consultations patient/ principal SP</i>						
1	2	8.3	1	5.9	3	7.3
2–3	6	25.0	0	–	6	14.6
4–9	6	25.0	7	41.2	13	31.7
10–17	9	37.5	7	41.2	16	39.0
20–80	1	4.2	2	11.8	3	7.3
<i>Attending doctor received some training in culturally sensitive health care</i>						
no	8	42.1	8	50.0	16	45.7
yes	11	57.9	8	50.0	19	54.3
<i>Attending SP received some training in culturally sensitive health care</i>						
no	4	16.7	5	29.4	9	22.0
yes	20	83.3	12	70.6	32	78.0
<i>Attending doctor's age in 2002</i>						
34–35	4	21.1	4	25.0	8	22.9
38–40	8	42.1	2	12.5	10	28.6
44–56	7	36.8	10	62.5	17	48.6

Table 1 Continued

Attributes/Experiences	Male Asylum Seekers		Female Asylum Seekers		Total	
	#	%	#	%	#	%
<i>Attending SP's age in 2002</i>						
26–33	5	20.8	5	29.4	10	24.4
35–36	11	45.8	3	17.6	14	34.1
41–43	8	33.3	9	52.9	17	41.5
<i>Asylum seeker's age in 2002</i>						
18–24	7	29.2	1	5.9	8	19.5
25–30	7	29.2	5	29.4	12	29.3
31–35	5	20.8	3	17.6	8	19.5
37–40	4	16.7	4	23.5	8	19.5
42–58	1	4.2	4	23.5	5	12.2
<i>Asylum seeker's highest education</i>						
completed post-secondary	4	16.7	9	52.9	13	31.6
some post-secondary	3	12.5	2	11.8	5	12.2
some secondary	15	62.5	4	23.5	19	46.3
some primary/no formal	2	8.4	2	11.8	4	9.7

SPs between 4 and 9 times on health matters, 16 cases with 10 to 17 interactions (39 per cent), and 3 (7 per cent) with between 20 and 80 encounters. Female ASY were more likely than the males were to have experienced 4 or more medical consultations with their principal attending nurse.

The interviewed physicians were more likely than the attending support professionals were to report that they had never received any training in how to offer culturally sensitive healthcare (46 per cent and 22 per cent of the cases, respectively). Only one case involved a doctor and one case involved a nurse who had received ‘extensive’ training in the provision of culturally sensitive care. The rest of the ASY had been treated by clinicians who had ‘only partly’ received this type of training.

The TC framework encompasses five separate, but interrelated, skill domains: analytic, emotional, creative, communicative, and functional (see Koehn and Rosenau 2002). Through structured literature review, the author adapted the framework’s generic skill sets to the transnational healthcare encounter (Koehn 2004: 72–78). Table 2 presents an outline of key healthcare-related skills in each TC domain that emerged from this review.

Medical-encounter participants are expected to demonstrate different levels of transnational competence. This study assessed each participant’s overall level of TC intersubjectively. A conceptually and empirically based explanation of the core items used to measure each TC domain can be found in Koehn (2004: 78–80). Examples of questions included under the various skill domains are: ‘understands

Table 2

Selected Healthcare-Related Skills, by TC Domain

Analytic	Communicative
Ability to understand: conditions that led the patient to leave country of origin healthcare conditions the patient faces in host society the other's personal beliefs regarding the causes, treatment, and prevention of illness effects of migration and post-migration experiences on the patient's current and prospective physical/mental health status and needs	Ability to: use other's first language or mutually understood third language use interpreters effectively when necessary demonstrate culturally appropriate nonverbal behaviour express (encourage expression of) healthcare questions and worries express (encourage expression of) healthcare doubts and disagreements
Emotional	Functional
Ability to: empathize with and validate the other's healthcare beliefs and practices (biomedical, alternative, and ethnocultural) value and reinforce resilience maintain personal interest in and concern about the other demonstrate openness to meriting acceptance in the other's culture	Ability to: demonstrate genuine caring for the other's personal situation avoid treating the other in an upsetting manner relate in a way that builds the other's trust take into consideration the influence of family/community on patient's health/illness give/request alternatives and choices before decisions reached activate host-society and migrant- community resources likely to enhance patient's health by addressing social-context inequities
Creative/Imaginative	
Ability to: contribute/encourage specific problem-solving ideas articulate complementary combinations of biomedical and ethnocultural approaches recommend healthcare practices and structural strategies suitable for local conditions	

conditions that led [the patient] to leave his/her country of origin?' (analytic); 'shows openness to accepting [patient's/clinician's] health-related beliefs and practices?' (emotional); 'recommends healthcare practices or coping strategies that are suitable for the conditions that migrants face in Finland?' (creative); 'expresses (encourages expression of) health-related worries and questions?' (communicative); 'relates to you in a way that helps you trust him/her?' (functional). Each

study participant rated possession and demonstration of skill measures by her/himself and the other team member(s) using a uniform three-point response set: 'yes'/always (coded or, in the case of negatively worded items, reverse coded as '1'); 'partly'/sometimes (coded as '2'); or 'no'/never (coded or reverse coded as '3'). On the correspondence of questionnaire-based patient reports regarding physician behaviour with audiotape analysis, see Kaplan *et al.* (1995: 1186).

The data-analysis procedure for estimating participant TC involved combining the separate, case-specific, subjective evaluations received from the asylum seeker and the other medical-encounter participant(s) (doctor and/or SP). First, we calculated the interviewee's mean score for each skill domain. Lower mean scores indicate higher TC evaluations. The researcher assigned each study participant, as well as the team as a whole (physician, SP, and ASY), a score for overall transnational competence for each case-specific set of encounters that is based on the mean score for all five skill domains (also see Barry *et al.* 2001: 499). Thus, each participant's overall TC evaluation consists of his/her composite mean score for analytic (5 items), emotional (6 items), creative/innovative (5 items), communicative (7 items), and functional (8 items) transnational competence. Approximately 90 per cent of the overall TC assessments are based on privately and independently contributed subjective evaluations of the same behaviour reported by the principal attending physician, the principal attending support professional, and the sampled asylum seeker. (The remaining 'dyad' cases involve only one clinician and the ASY.) In the interests of advancing completeness and reducing the bias inherent in single-source interviews (see Breitmayer *et al.* 1993: 238), this triad form of triangulation research analyses interaction-generated reflections reported by the primary participants in clinical encounters (see Denzin 1970: 301–302) that are unaffected by the intrusion of an outside observer. This approach recognizes that the attitudes and behaviour of patients and providers influence each other as well as the outcomes of the healthcare undertaking (see Smedley *et al.* 2003: 12, 237).

In the results analysed here, we designated study participants with a mean score of 1.27 to 1.5 on the scale of 1 to 3 to be relatively highly competent and those from 1.51 to 2.10 as possessing relatively little competence. The choice of cut points always is somewhat arbitrary (van Ryn and Burke 2001: 816). The analysis reported here utilizes dichotomous breaks at the mid-way point where at least 20 per cent of each group fit in the high-TC category and at least 50 per cent fit in the less-TC category. Table 3 shows the overall intersubjective transnational competence score attained by physicians, support professionals, asylum seekers, and each collective healthcare team. Study participants gave attending physicians the lowest overall transnational-competence scores (20 per cent 'high TC'). In comparison, the interviewees judged twice the proportion of both attending support professionals and asylum seekers to possess high TC.² Participants rated SPs higher than they did ASY (49 per cent versus 42 per cent 'high TC'). Among the 39 available three-member and two-member

*Table 3***Overall Intersubjective Transnational Competence (TC) Scores: Physicians, Support Professionals, Asylum Seekers, and Healthcare Teams**

Group	High TC		Relatively little TC		Total	
	#	%	#	%	#	%
Attending physicians	7	20.0	28	80.0	35	100.0
Attending SPs	19	48.7	20	51.3	39	100.0
Asylum seeker patients	17	41.5	24	58.5	41	100.0
Healthcare team	15	38.5	24	61.5	39	100.0

healthcare teams, 15 emerged as highly competent and 24 as relatively less competent.

Study Results: Congruent Perspectives in Medical Encounters Involving Asylum Seekers

The findings reported in the first part of the article explore congruent and divergent perspectives among asylum seekers and their principal attending physician on critical healthcare issues. The analysis presented in this part also compares perspectives across four country-of-origin groupings (former Soviet Union, former Yugoslavia/Albania, Kurdish areas in Iran, Iraq, and Turkey, and Somalia/Angola). Three sets of assessments that bear in important ways on mutual understanding in medical encounters involving asylum seekers and refugees provide the focus of attention: perceived health status, perspectives on mental health/illness, and healthcare beliefs/values.

Perceived Health Status

Effective healthcare for forced migrants depends, in part, on shared understanding of the seriousness and specific nature of the medical problems that displaced persons bring with them to the receiving country. We independently elicited patient and attending physician assessments of the asylum seeker's state of health/illness. Here, we first compare ASY and physician assessments for cognitive match regarding the seriousness of the patient's condition at the time s/he arrived in Finland. Then, we compare the explanations each encounter participant provided for the post-arrival contact(s).

Assessments of asylum seeker's health at time of arrival in Finland. By comparing self-reports with 'more objective measures of morbidity' across diverse ethnic groups, Chandola and Jenkinson (2000: 157–158) have demonstrated that 'the use of a single item measure of self-rated health to measure health status in

different ethnic groups is valid' (also see Lau 1997: 65–66 and van Ryn and Burke 2001: 816). We assessed subjective health status through answers to a simple general-health question. Points on the self-rated continuum were (1) no health problems, (2) non-serious health problem(s), (3) somewhat serious health problem(s), (4) very serious health problem(s), (5) life-threatening health problem(s).

Asylum-seeker subjective assessments of their health status at the time of arrival in Finland on the five-point continuum were congruent with the attending physician's evaluation in only 7 (20 per cent) of the available cases (N = 35). Over half of the attending doctors (51 per cent) assessed the ASY's health condition at the time of arrival as less serious than the asylum seeker's self-evaluation; in 29 per cent of the cases, the patient reported a less-serious assessment.

Table 4 shows that participating physician assessments of ASY health at the time of arrival were incongruent with patient self-assessments across all nationality groups. The doctor's perspective most frequently differed from the asylum seeker's self-assessment in the cases involving patients from the former Yugoslavia (86 per cent). Physicians were most likely to judge the ASY's health upon arrival in less serious terms than the asylum seeker's self-assessment in the case of interviewees from the former Yugoslavia (57 per cent); they were least likely to do so among those from the former Soviet Union (46 per cent).

Explanations for contact(s). Accurately ascertaining the reason(s) people seek medical care constitutes 'one of the most challenging tasks in evaluating the patient's primary problem(s)' (Lipkin *et al.* 1995: 68; also see Johnson *et al.* 1995: 157). Clinicians are particularly challenged by consultations with ethno-culturally dissimilar patients. In this study, the researcher independently asked both asylum seekers and physicians to identify up to three important reasons for the healthcare contact(s) experienced over the full course of their consultations (see Hjortdahl and Laerum 1992: 1290). The vast majority of contact

Table 4

Attending Physician/Asylum Seeker Assessments of Patient's Health at Time Arrived in Finland, By Homeland Clusters

Asylum seeker's homeland	Doctor/Asylum seeker assessments		Total	
	Differ (%)	Same (%)	#	%
Former Soviet Union	76.9	23.1	13	100
Former Yugoslavia/Albania	85.7	14.3	7	100
Kurdish areas	81.8	18.2	11	100
Somalia/Angola	75.0	25.0	4	100
Total	80.0	20.0	35	100

Table 5

Attending Physician/Asylum Seeker Reported Reasons for Healthcare Contact(s): By Homeland Clusters

Asylum seeker's homeland	Physician/Asylum seeker explanations			Total	
	Same (%)	ASY > #/serious (%)	Dr > #/serious (%)	#	%
Former Soviet Union	30.8	46.2	23.1	13	100
Former Yugoslavia/ Albania	33.3	50.0	16.7	12	100
Kurdish areas	0.0	45.5	54.5	11	100
Somalia/Angola	25.0	25.0	50.0	4	100

explanations offered by both types of study participants referred to non-communicable, non-life-threatening health complaints (see McQueen *et al.* 2001: 293–322; Burnett and Peel 2001: 545). In 45 per cent of the available cases, however, the contact explanations provided by ASY included either a larger number of minor illnesses or more serious health problems (communicable illness, mental health problem(s), or life-threatening illness) than their doctor reported. In another 33 per cent of the cases, the physician's explanations involved a more extensive list and/or more serious problems relative to the asylum seeker's report. Both parties gave explanations for their contact(s) that were congruent in type and quantity in only 23 per cent of the cases.

The Table 5 data show that differences prevail in the specific reasons that most attending physicians and ASY gave for their healthcare contact(s) across all of the regional clusters. Kurdish asylum seekers and their attending physician diverged in all 11 cases. In more than half of these cases (54.5 per cent), the doctor reported a longer list of minor illnesses or more serious problems than the patient did. In roughly half of the cases involving asylum seekers from all of the regional clusters except Somalia/Angola, ASY mentioned more serious (and more) health problems than the attending physician reported. One possible explanation for these findings is that attending physicians in Finnish resettlement centres tend to overdiagnose patients from Africa, to underdiagnose those from Europe/Central Asia, and to underdiagnose and overdiagnose persons from the Middle East. Alternatively, the observed differences could be due to over/under self-diagnosis by patients from certain regional groupings. Most important in terms of this study, the extent of patient/physician congruence in explanations for the medical encounter(s) is uniformly low.

Mental Health/Illness Perspectives

To what extent are asylum-seeker perceptions of mental health needs, causes, and effects recognized and shared by attending physicians in the transnational

medical consultation? Odell *et al.* (1997: 537) note that ‘with few exceptions, evaluation of the capacity of general practitioners to recognize psychiatric disorder in their patients has failed to consider the role of ethnic diversity in the consultation process . . .’ Are ‘hidden’ mental health symptoms and causes more likely for some regional groups than for others? This section explores physician and ASY mental health perspectives in comparative perspective.

Mental health problems and symptoms. Twenty-six of the sampled asylum seekers (70 per cent of the 37 responding) reported that they had experienced one or more mental health problems in Finland. Among this group, 20 study participants (56 per cent) mentioned depression and 16 (44 per cent) reported that insomnia accompanied their mental health problem.³ Seventeen ASY (45 per cent) felt that their physical health in Finland had been seriously/partly negatively affected by their mental health problem(s). These subjective findings are consistent with symptomatic-checklist studies from other non-clinical samples that confirm that sizeable proportions of ‘refugees of all ages constitute a population at risk of severe and persistent psychological distress’ (Miller 1999: 286–287; Silove *et al.* 1997: 351; Ager *et al.* 2002: 75; Drozdek *et al.* 2003: 208; Ackerman 1997: 340).

In 16 (62 per cent) of the 26 dual-report cases where asylum seekers reported mental health problems in Finland, attending physicians concurred that their patient had experienced some broadly defined ‘mental health problem’ (also see de Girolamo 1994: 267), without necessarily reaching a psychiatric diagnosis (also see Odell *et al.* 1997: 540; Borowsky *et al.* 2000: 381). In the other 10 cases (39 per cent), ASY mentioned experiencing one or more mental health problems, but their doctor reported none.

Although attending physicians concurred on the presence of a mental health problem in more than half of the ASY-reported cases, most doctors did not report the specific problem(s) cited by the interviewee. Depression, the most frequently cited mental health problem among the asylum seekers in this study, offers one revealing illustration (also see Leong and Lau 2001: 206–207; Borowsky *et al.* 2000: 387). Although the ‘recall’ method based on direct physician questioning utilized in this study ‘almost always’ yields ‘higher rates of recognition’ in comparison with chart reviews that ‘confound record-keeping practices with clinical recognition’ (Robbins *et al.* 1994: 808), the interviewed physicians did not report depression in 12 (60 per cent) of the 20 cases where ASY reported experiencing it in Finland.⁴ Reports regarding depression were most likely to diverge in the case of asylum applicants from Kurdish areas (83 per cent, N = 6) and most likely to be congruent when the cases involved ASY from the former Yugoslavia/Albania (67 per cent, N = 3).

The ability of clinicians to detect symptoms of mental health problems provides further insight into the presence/absence of shared perspectives. In terms of symptoms that can reveal the presence of depression (see Struwe 1994: 319), the interviewed asylum seekers reported the following: insomnia (16 study participants), loneliness (11), and suicidal thoughts/attempts (1). The ASY’s principal

attending physician showed awareness of insomnia in 10 of these cases (63 per cent), but stated that loneliness was not present in 10 of the 11 cases (91 per cent) where participating ASY acknowledged it to the researcher. The attending doctor also reported an absence of suicidal thoughts/attempts in the one case involving a patient who responded 'yes' when asked if s/he had experienced such in Finland.

Source of problems. Asylum seekers frequently cited place-of-origin experiences and/or experiences in Finland as sources of their mental health problems. Twenty-two of the 26 problem-reporting ASY (85 per cent) agreed that the mental health challenges they experienced in Finland were caused, at least in part, by personal experiences in their place of origin. In comparison, 79 per cent of the interviewed asylum seekers in an Australian study reported exposure to at least one type of major pre-migration trauma (Silove *et al.* 1997: 355–356). On the long-term psychological consequences of torture for victims, see Musisi *et al.* (2000: 81, 83–84), Mollica *et al.* (1998: 550), and Levy (1999: 240–242).

With few exceptions, studies of refugee mental health have 'tended to emphasize the impact of past events, particularly those in the country of origin and in the process of flight' and have devoted little attention to 'the impact of post-migration experiences on mental health' (Watters 2001: 1711; also see Derges and Henderson 2003: 88). In 1997, Silove *et al.* (p. 356) suggested that 'particular post-migratory living stresses faced by asylum-seekers may interact with and possibly exacerbate their emotional and post-traumatic symptoms' (also see Derges and Henderson 2003: 90, 95, 97; Liebkind 1996: 176). Half (13) of the interviewed asylum applicants in this study cited post-arrival experiences in Finland as contributors to their problem(s) (also see Pernice and Brook 1996: 515–516). From other findings, we would expect such exile stressors to include 'loss of one's community and social network, the loss of important life projects, changes in socioeconomic status and related concerns about economic survival, the loss of meaningful structure and activity in daily life, and the loss of meaningful social roles' (Miller 1999: 284, 294–302; Muecke 1992: 520; Ager *et al.* 2002: 78; Orley 1994: 194–195; Davey 1999: 266–267) as well as experiences of discrimination and hostility (Liebkind 1996: 175–176; Tiilikainen 2001: 312; Silove and Ekblad 2002: 402), 'fears of being sent home' (Watters 2001: 1711; Sinnerbrink *et al.* 1997: 467), delays in processing asylum petitions (Carrington and Proctor 1995: 16), and difficulties dealing with immigration officials (Silove *et al.* 1997: 351, 353).

The dual-interview data collected in this study suggest that attending physicians are much less likely to be aware of the impact that post-migration experiences exert on asylum seekers' mental health than they are of pre-arrival contributing factors. Both reception-centre residents and their doctors cited place-of-origin experiences as contributors to the ASY's mental health problem(s) in Finland in 12 of 22 cases (55 per cent). However, attending physicians did not see experiences in Finland as contributing to their patient's mental health problem(s) in 8 of the 13 cases (62 per cent) where the asylum petitioner felt they were at least part of the cause for his/her problem(s). Doctors were most likely to

miss the salience for ASY of sending-society stressors among Kurdish asylum seekers (60 per cent, $N = 5$) and of receiving-society stressors in clinical encounters involving study participants from the former Yugoslavia/Albania (both cases) and the three Kurdish areas (3 of the 4 cases).

Perspectives on Healthcare Beliefs/Values and Practices

In this section, we are interested in the extent to which host-country physicians accurately assessed the ASY's outlook on non-standard (see Hiegel 1994: 293–294) approaches to healthcare. Western doctors are prone to overlook the importance of ethnocultural beliefs and values among migrants, 'even though these beliefs may affect acceptance of healthcare, compliance, and treatment outcomes' (Fishman *et al.* 1993: 160; also see Nudelman 1994: 190–191; Fadiman 1997).

When asked if they valued the beliefs and practices of their culture regarding the causes, treatment, and prevention of illness, 19 of the ASY (46 per cent) replied that they did, 14 (34 per cent) chose 'only partly,' and 8 (20 per cent) said they did not. The attending physician accurately gauged the asylum seeker's response in only 10 of the 33 available cases (30 per cent). Ten doctors said that they had no idea regarding their patient's outlook on the healthcare beliefs and practices of their culture. Five physicians (15 per cent) underestimated the extent to which their resettlement-centre patient valued his/her cultural beliefs and practices and eight (24 per cent) overestimated such values. The attending physicians were most likely to misjudge/not detect the traditional beliefs and values of Kurdish and African patients (90 per cent and 100 per cent, respectively). They were most accurate (54 per cent) with regard to the geographically and culturally proximate asylum seekers from the former Soviet Union.

Physicians demonstrated even less awareness of migrants' ethnocultural usage practices than they did beliefs and values. In this study, 17 asylum seekers (42 per cent of the total) reported that they typically incorporated ethnocultural practices in their personal approach to healthcare; another 7 (17 per cent) indicated that they partly followed a cooperative treatment model that draws upon both indigenous and biomedical techniques. Seventeen other interviewees (42 per cent) did not use traditional healthcare approaches in Finland. Only 11 doctors (32 per cent of the 34 available cases) accurately assessed their patient's incorporation or non-incorporation of non-standard approaches in Finland. Among the rest of the interviewed physicians, 7 (21 per cent) underestimated and 8 (24 per cent) overestimated patient usage of traditional practices and 8 (24 per cent) had no idea regarding whether or not the asylum seeker utilized ethnocultural practices.

Cognitive Congruence, Outcome Perspectives, and Transnational Competence

Are the observed cases of congruence in patient/provider perspectives on health/illness, mental health, and ethnocultural healthcare as well as migrant

*Table 6***Congruent Physician/Asylum Seeker Patient Health/Illness Perspectives, By Overall TC Scores**

Overall TC	Same assessment of ASY's health at time of arrival in Finland		Same 3 explanations for ASY healthcare contacts	
	#	%	#	%
Dr relatively little TC	5	17.9	5	17.9
Dr high TC	2	28.6	3	42.9
SP relatively little TC	4	22.2	2	10.0
SP high TC	3	17.6	6	33.3
ASY relatively little TC	4	18.2	5	21.7
ASY high TC	3	23.1	4	23.5
Team relatively little TC	4	19.0	4	17.4
Team high TC	3	21.4	4	26.7

perspectives on three 'simple but meaningful' measures (Vega and Lopez 2001: 196) of healthcare outcomes (satisfaction, effectiveness, and future confidence) related to transnational competence on the part of doctor, asylum seeker, support professional, and/or the collective healthcare team? This section addresses this question with reference to study findings.

Health/Illness Perspectives

The findings presented in Table 6 show that high TC among physicians and ASY are related to congruence in perspectives regarding the asylum seeker's health at the time of arrival in Finland. Congruence in assessing the patient's health status at the time of his/her arrival in the new land was most likely to occur when the study participants judged the physician to possess a relatively high level of transnational competence (29 per cent versus 18 per cent among less-TC doctors). The Table 6 data also indicate that high-TC physicians and high-TC SPs were the most likely encounter participants to be associated with shared explanations regarding the specific reason(s) for the medical interactions(s). High-TC doctors were considerably more likely to offer congruent explanations in comparison with attending physicians who were judged to possess relatively little TC (43 per cent versus 18 per cent).

Mental Health Perspectives

Overall TC is related in interesting ways to congruent mental health assessments. The findings found in Table 7 indicate that high overall TC among attending

Table 7

Congruent Physician/Asylum Seeker Patient Mental Health Perspectives, By Overall TC Scores

Overall TC	Both report mental health problems		Both report depression		Both report place-of-origin causes		Both report in-Finland causes	
	#	%	#	%	#	%	#	%
Dr relatively little TC	11	61.1	4	26.7	7	50.0	5	45.5
Dr high TC	4	100.0	4	100.0	4	100.0	0	0.0
SP relatively little TC	7	50.0	4	40.0	5	45.5	3	37.5
SP high TC	9	90.0	4	40.0	7	77.8	2	40.0
ASY relatively little TC	9	64.3	5	50.0	8	72.7	3	37.5
ASY high TC	7	58.3	3	30.0	4	36.4	2	40.0
Team relatively little TC	9	60.0	4	36.4	7	58.3	4	40.0
Team high TC	7	77.8	4	44.4	5	62.5	1	33.3

physicians was particularly important in connection with congruent assessments of the presence of mental health challenges among asylum seekers and in recognizing place-of-origin contributors. High TC among attending nurses also was related to congruence in the identification of both mental health problems and pre-arrival contributors. More narrowly, the patient’s reported experience of depression in Finland was not reported by the attending physician in 75 per cent of the cases when the asylum seeker indicated that his/her doctor had *not* ‘encouraged me to express my health worries and concerns,’ but in only 46 per cent of the cases where the doctors reportedly encouraged/partly elicited such concerns (N = 19). This finding is consistent with Robinson and Roter’s discovery (1999: 1360) regarding the importance of inquiry by physicians in patient disclosure of psychosocial problems.

On the other hand, the Table 7 data show that high physician TC offered no advantage at all in identifying the presence/absence of post-migration stressors. In the Finland study, high transnational competence among support professionals and ASY were most likely to promote corresponding perspectives on the challenging matter of host-society contributors.

Ethnocultural Healthcare Perspectives and Practices

The study findings presented in Table 8 indicate that clinicians’ higher overall TC scores were not consistently related to greater congruence in assessments of ethnocultural healthcare beliefs and values. Indeed, doctors judged to possess relatively little TC proved considerably more likely than those with high TC to

Table 8

Congruent Physician/Asylum Seeker Patient Ethnocultural Healthcare Perspectives and Practices, By Overall TC Scores

Overall TC	Same assessment ASY's ethnocultural healthcare values		Same assessment ASY's ethnocultural healthcare practice	
	#	%	#	%
Dr relatively little TC	9	34.6	8	29.6
Dr high TC	1	14.3	3	42.9
SP relatively little TC	6	35.3	5	29.4
SP high TC	4	25.0	6	35.6
ASY relatively little TC	6	27.3	7	31.8
ASY high TC	4	36.4	4	33.3
Team relatively little TC	6	30.0	7	35.0
Team high TC	4	30.8	4	28.6

report accurately regarding the asylum seeker's appreciation for ethnocultural beliefs and practices (35 per cent and 14 per cent, respectively). The Table 8 data also suggest that high patient TC can contribute to clinician understanding of the value that asylum seekers place on ethnocultural approaches.

When it comes to assessing patient practice, however, overall physician TC made the most difference (Table 8). Fully 43 per cent of the doctors judged to be high-TC accurately assessed the extent to which the ASY patient relied upon ethnocultural healthcare methods in Finland.

Asylum-seeker Assessments of Healthcare Outcomes

Asylum-seeker assessments of healthcare outcomes also offer important information about the nature and likely impact of patient/provider interactions. Here we first consider three outcome indicators: patient satisfaction with the results of the attending doctor's care (also see Barry *et al.* 2001: 492), healthcare effectiveness in the new context, and future confidence in the attending physician's recommended measures. Then, we explore the relationship of participant TC to ASY perspectives on these healthcare outcomes.

Based on studies of patient/physician race concordance, one would expect to discover lower satisfaction in ethnoculturally discordant encounters (see Cooper *et al.* 2003: 911–912; Haidet *et al.* forthcoming). In this study, less than half (46 per cent) of the asylum petitioners reported that they felt (very) satisfied with the care provided by their doctor; 27 per cent were (very) dissatisfied. The remaining 'neither satisfied/nor dissatisfied' category probably includes ASY

holding ambivalent feelings. In many cases, 'patients obviously appreciate the powers of Western therapies but deplore the "inhuman" quality of care' (Kleinman 1980: 303, 305).⁵ In comparison with other studies, these data indicate less patient satisfaction, perhaps in part because the interviews occurred after the asylum seekers had ample time for reflection on the full set of clinical encounters (see Korsch *et al.* 1995: 480; Roter and Hall 1992: 133).

Effective self-care behaviour, which emphasizes personal/group responsibility (Salloway *et al.* 1997: 75) and includes 'a concern for general health maintenance and improvement in addition to behaviours that are problem-specific' (Gochman 1997a: 7, 10, 12), can be particularly challenging for forced migrants who have experienced adversity and now find themselves in strange surroundings where they are separated from support networks, familiar environmental (including climatic) surroundings, country-of-origin healthcare systems, and adequate economic resources. Given such vulnerabilities, some forced migrants find themselves 'trapped in past lives and traumas and cannot easily find ways out of their current situation' (Mestheneos and Ioannidi 2002: 316). However, many others demonstrate extraordinary innovation and resilience in protecting and promoting personal and family wellness (see Kopinak 1999: 79–80; Ryff and Singer 2003: 181–182, 192–193; Watters 1998: 285–286; Colson 2003: 8). Scholars have noted the tendency to overlook refugee resources and resilience (Muecke 1992: 520; Watters 2001: 1710; DeSantis 1997: 26) due to neglect of extra-clinical forms of securing healthcare, including education and self-help, support from family, friends, and community members, networking with others experiencing the same condition, and ethnocultural methods (Trostle 1997: 113; Perry 2001: 99; Roter and Hall 1992: 9–10; Valtonen 1998: 57). In this study, two-thirds of the asylum seekers replied that they have been effectively attending to their health since they arrived in Finland. Another 24 per cent answered 'partly'. Only 10 per cent responded that they have not been at all effective in taking care of their health in Finland.⁶

In assessing clinical encounters intersubjectively and prospectively, it is important to explore future expectations along with current feelings. Therefore, we asked patients to report on their level of confidence that the physician's treatment and healthcare recommendations would be helpful for their health over the 'next year or so'. Less than half of the asylum seekers (46 per cent) expressed confidence in their doctor's healthcare measures (including 4 who were 'very confident'). About 30 per cent were not confident (including 4 who were 'very unconfident'). The rest (24 per cent) selected 'neither confident/not confident', suggesting uncertain, ambivalent, and contradictory feelings (also see Brown and Rusinova 2002: 164–165).⁷

The findings presented in Table 9 suggest that high transnational competence is related in noteworthy ways to all three outcome perspectives. In terms of asylum-seeker satisfaction with the healthcare received from Finnish doctors at reception centres, high physician TC along with high ASY transnational competence stand out as influential (and modestly statistically significant) variables. For instance, more than 70 per cent of the asylum petitioners who consulted high-TC

Table 9

Asylum Seeker Outcome Perspectives, By Overall TC Scores and Other Factors												
Overall TC	Satisfied/dissatisfied with doctor's care				Personal effectiveness in healthcare in Finland				Confidence in doctor's recommended measures for next year or so			
	<i>v/satis</i>		<i>not satis</i>		<i>yes, effectv</i>		<i>no/partly</i>		<i>v/confid</i>		<i>not confid</i>	
	#	%	#	%	#	%	#	%	#	%	#	%
Dr relatively little TC	9	32.1	19	67.9	18	64.3	10	35.7	11	39.3	17	60.7
Dr high TC	5	71.4*	2	28.6	4	57.1	3	42.9	5	71.4	2	28.6
SP relatively little TC	6	30.0	14	70.0	12	60.0	8	40.0	7	35.0	13	65.0
SP high TC	11	57.9*	8	42.1	13	68.4	6	31.6	12	63.2*	7	36.8
ASY relatively little TC	8	33.3	16	66.7	14	58.3	10	41.7	9	37.5	15	62.5
ASY high TC	11	64.7+	6	35.3	13	76.5	4	23.5	10	58.8	7	41.2
Team relatively little TC	8	33.3	16	66.7	15	62.5	9	37.5	9	37.5	15	62.5
Team high TC	9	60.0	6	40.0	10	66.7	5	33.3	10	66.7*	5	33.3
ASY male	9	37.5	15	62.5	17	70.8	7	29.2	9	37.5	15	62.5
ASY female	10	58.8	7	41.2	10	58.8	7	41.2	10	58.8	7	41.2
Dr/ASY not gender matched	4	26.7	11	73.3	10	66.7	5	33.3	5	33.3	10	66.7
Dr/ASY gender matched	10	50.0	10	50.0	12	60.0	8	40.0	11	55.0	9	45.0
ASY 18-30 years of age	8	40.0	12	60.0	14	70.0	6	30.0	10	50.0	10	50.0
ASY 31-58 years of age	11	52.4	10	47.6	13	61.9	8	38.1	9	42.9	12	57.1
ASY no post-secondary education	7	30.4	16	69.6	17	73.9	6	26.1	10	43.5	13	56.5
ASY some post-secondary education	12	66.7+	6	33.3	10	55.6	8	44.4	9	50.0	9	50.0
ASY 1-3 contacts with doctor	6	33.3	12	66.7	12	66.7	6	33.3	7	38.9	11	61.1
ASY 4-30 contacts with doctor	8	47.1	9	52.9	10	58.8	7	41.2	9	52.9	8	47.1

*p < 0.10.
+p < 0.05.

physicians reported being (very) satisfied, while less than one-third of those who met with doctors judged to possess relatively little TC held a positive assessment about the care they had received ($p = 0.06$). The educational level of asylum seekers also is statistically associated with higher satisfaction ($p = 0.02$), suggesting that there is a connection between higher educational attainments and patient TC and that attending physicians and nurses find it easier to act in a transnationally competent manner in medical interactions with relatively well-educated patients. Gender concordance (also see Haidet *et al.* forthcoming), patient age, and number of medical encounters all exerted little or no effect on ASY satisfaction with the physician's care.

High physician and nurse TC (along with high TC among all participants in the medical encounter) also were particularly strongly associated with asylum seekers' future confidence in the approaches recommended by the attending doctor. Age, education, and number of medical consultations made little difference in this regard (Table 9).

In terms of effectiveness in taking care of one's health subsequent to arrival at the reception centre, high physician TC was not a factor. When it comes to healthcare effectiveness/resilience in the new land, the Table 9 data suggest that high asylum-seeker TC makes the most difference. Younger, male, less well-educated study participants also were more likely than were older, female, and better-educated ASY to report that they have been personally effective in taking care of their health in Finland. Patient/physician gender concordance and more clinical contacts are inversely related to reported self-care effectiveness. These results suggest that patient transnational competence merits inclusion among the psychosocial factors that promote refugee resiliency and/or buffer physical and mental health risks.

Discussion

In ethnoculturally discordant medical encounters, most healthcare perception gaps continue to 'go unrecognized, consciously at least, by everyone but the few researchers who tease them out' (Roter and Hall 1992: 10). In this study, we found that the perspectives of interviewed physicians and asylum seekers consistently diverged across critical healthcare-related issues: physical and mental health status and illness explanations, contributors to mental health problems and symptoms, and the value attributed to ethnoculturally familiar health beliefs and healthcare practices. The widespread presence of transnational dissonance on such critical matters suggests that Western doctors and asylum-seeking patients are not connecting in most of their medical encounters and might even be operating at cross-purposes. Such disconnects are particularly problematic in terms of prospects for offering adequate transnational healthcare when they result from inaccurate assessments on the part of attending clinicians (Struwe 1994: 315). It is unlikely, moreover, that an effective partnership between indigenous healing methods and Western mental health therapies (see Mollica 1994: 98) will develop when caregivers are unaware of their patients' perceptions

regarding the presence, symptoms, and root causes of personal mental health problems and of their post-migration use of non-biomedical approaches (also see Johnson *et al.* 1995: 157; Kagawa-Singer and Kassim-Lakha 2003: 582–583). In extreme cases, misdiagnoses and ‘overdiagnoses’ can result in treatment procedures that refugees perceive as ‘inappropriate and terrifying’ (Pernice and Brook 1996: 517). Moreover, overemphasis by care providers on the ‘negative marker’ of trauma victim can perpetuate forced-migrant marginality by diverting host-society and care-receiver attention from structural features that preclude the reconstitution of viable lives—including discrimination in employment, political scapegoating, and state restrictions on accepting and resettling displaced persons (Eastmond 1998: 174, 177).

On most issues explored in this study, the presence of in/congruent healthcare perspectives also was related to the national origin of asylum seekers. The perspectives of attending Finnish physicians were particularly likely to diverge from those expressed by Kurdish asylum seekers. We encountered less than 25 per cent congruence in provider/Kurdish perspectives on 10 of 14 critical dimensions of healthcare. The perspectives of ASY from the former Soviet Union and from the former Yugoslavia/Albania also tended to be incongruent with those of the principal attending physician in critical issue areas. Most of these differences were less dramatic than in the Kurdish cases. We most commonly encountered congruent views among doctors and patients in cases involving asylum seekers from Somalia/Angola.

Although they were the least likely of the three types of participants in the medical interview to possess high overall TC, the transnational competence of attending physicians proved to be related especially strongly to shared perspectives on health status at the time of arrival in the receiving country, to common explanations for health/illness, to patient utilization of ethnocultural healthcare methods in Finland, and to congruent perspectives regarding the presence of mental health problems, depression, and place-of-origin contributors. While physician competence is particularly important in many relational aspects of the medical consultation, the overall TC possessed by support professionals and by migrants themselves remains relevant and complementary. For instance, high asylum-seeker TC was particularly helpful in connection with concordant assessments of ASY orientations toward ethnocultural approaches. In addition, 40 per cent of the high-TC support professionals (and none of the high-TC physicians) were involved in cases where attending doctors and ASY gained shared understanding of the role of receiving-society experiences as a source of mental health problems—suggesting that, in some but not all respects, transnationally competent nurses and social workers fill vital bridging roles in transnational healthcare. Bridging roles include building trust by first assisting arriving asylum seekers in addressing social, economic, and logistical challenges (see Watters 2001: 1713; Derges and Henderson 2003: 94).

These findings are interesting from an exploratory, hypothesis-building perspective. The mix of respondents by country of origin, length of residence in Finland, number of contacts with care providers, gender, gender match, age, and

educational background provided a valuable comparative base for study. Any bias introduced by the higher educational attainments of the sample in comparison with the populations of the participants' country of origin would be expected to increase the likelihood of congruent assessments and the presence of TC. Although participants included a sizeable proportion of the adult population of the largest nationality groups resident at the five reception centres throughout summer 2002, the relatively small number of cases (41) constitutes one limitation of the study, particularly in terms of statistical procedures (also see Robbins *et al.* 1994: 806; Ager *et al.* 2002: 77). The cross-sectional nature of the study constitutes another limitation. While clinicians had records to refer to, some patients were expected to recall medical consultations that took place more than a year prior to the interview. In addition, these results cannot be generalized to other combinations of clinician/patient ethnicity or to asylum-seeker interactions with, for instance, surgeons rather than general practitioners. Further research is needed that will address the limitations of this exploratory study. Ideally, future research will involve a larger sample of asylum seekers, will be longitudinal and cross-national in design, and will include unobtrusive observations. The initial findings reported here will be more compelling if replicated among larger and even more diverse populations.

Conclusion

When Western clinicians interact with asylum seekers of diverse national origins, the transnational competence demonstrated by participants in the healthcare consultation is valuable for securing congruence in most, but not all, vital health-related perspectives and for advancing positive outcome assessments. Specifically, we found that transnational competence makes a difference in terms of asylum-seeker satisfaction with medical encounters in the receiving country, confidence in the future value of the attending physician's healthcare approach, and self-reported healthcare effectiveness in one's new surroundings—perspectives with the potential to exert a major positive impact on the health of forced migrants. High physician TC is most related to clinical satisfaction and confidence and high asylum-seeker TC is most related to healthcare effectiveness in the new social context. High support professional and team TC also contribute to all three positive outcome perspectives. On the whole, the study results point to the value of transnational-competence training for all participants in an era of mobility upheaval and ethnically discordant medical encounters.

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1. Leong and Lau (2001: 206–207) point out that under-diagnosis also 'can occur when a clinician indiscriminately applies a cultural explanation to explain a patient's

presentation. For example, attributing an extremely reserved interpersonal style and flat affect to a cultural communication norm rather than to depressive symptoms of withdrawal and anhedonia.'

2. Participants judged neither of the two asylum seekers with postgraduate training, 64 per cent of those who had completed post-secondary education, 60 per cent of those with some (but not complete) post-secondary education, and only 30 per cent of the asylum applicants with secondary-school education or less to possess high TC. Team members were twice as likely to rate female ASY highly in terms of overall TC in comparison with males (59 per cent versus 29 per cent). Exactly 46 per cent scored ASY from the former Yugoslavia/Albania and from Kurdish areas as high-TC. Only 39 per cent of the asylum seekers from the former Soviet Union and 25 per cent of those from Somalia/Angola received overall assessments of high-TC.
3. The complete list of mental health problems and symptoms explored in the interview covers 'the most common symptoms and signs that appear in refugees across different cultures' (Struwe 1994: 332; also see Orley 1994: 196–199).
4. Even in ethnically matched consultations, 'more than half of all patients with depression or anxiety in primary care go unrecognized by their physicians' (Robbins *et al.* 1994: 808; also see Kavanagh 1999: 231; Odell *et al.* 1997: 537; Borowsky *et al.* 2000: 387).
5. In light of the particularly widespread lack of perceptual congruence among doctors and Kurdish ASY documented in the first section of this article, it is not surprising that attending physicians underestimated the dissatisfaction (or overestimated the satisfaction) of nearly three-fourths of their Kurdish patients. They also underestimated the satisfaction of asylum petitioners in 43 per cent of the cases selected from the former Yugoslavia/Albania, but in only 15 per cent of those from the former Soviet Union.
6. Doctors proved far more likely to underestimate patient-reported resilience in cases involving ASY from Africa and the Middle East than they were when evaluating asylum seekers from Europe and Central Asia. In addition, they were most likely to possess a more inflated view of their patient's healthcare effectiveness than the latter held in cases involving ASY from the former Soviet Union (54 per cent, versus less than 30 per cent of the other encounters).
7. There was considerably less congruence in future outlook in clinical encounters involving ASY from the former Soviet Union than in the other cases (7.7 per cent and 27.2 per cent, respectively). Half of the asylum seekers from Somalia/Angola versus only one-quarter of the others showed more confidence in future health outcomes than their attending physicians did.

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