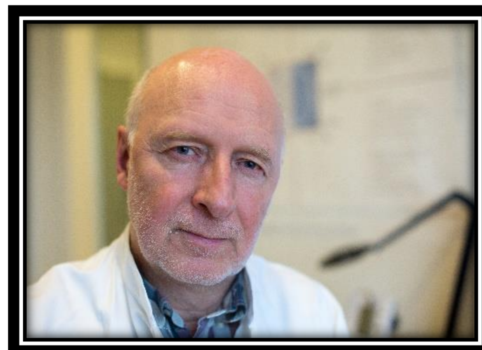
Health Care Inequalities, Ethnic Minorities and COVID-19 in Denmark

An interview with Dr. Morten Sodemann



Dr. Morten Sodemann, is a professor of global and migrant health at the University of Southern Denmark, SDU and the founder and director of the Migrant Health outpatient clinic at Odense University Hospital, OUH established in 2008. He serves as vice chairman of the Danish Society for Migrant Health.

With extensive experience as a teacher and a research supervisor, Sodemann is actively involved in postdoctoral training in cross-disciplinary clinical skills. He has also developed a migrant health curriculum at the medical school of SDU.

In this interview with COVID cluster researcher Saira Mian, Dr. Morten shares insights about existing inequities in the healthcare system in Denmark and his experiences with ethnic minority patients during the COVID-19 pandemic in Denmark.

Saira: *Please tell me about the inception of the migrant health clinic?*

Dr. Morten Sodemann: As a medical doctor, I encountered patients from non-western backgrounds who were often caught between psychiatric and physical healthcare specialties within the Danish healthcare system. One patient experience that underscored the dire need for improvement in the health system involved a young Tanzanian woman admitted to the hospital during one of my weekend shifts. Her medical records indicated tuberculosis and HIV positivity, alongside symptoms attributed to "cultural shock." Sadly, she passed away three weeks later, highlighting the fatal consequences of such diagnosis. Terms like "ethnic pain" or "cultural symptoms" exemplify discriminatory medical practices against non-western patients. I did my PhD research in childhood infectious diseases in West Africa, where I developed a methodology involving social and verbal autopsies in my interviews with mothers who had lost a child to disease. I discovered systemic social capital issues, wherein patients were denied proper attention and care unless they had connections within the healthcare system. Upon returning to Denmark, I encountered similar challenges faced by migrants and refugees with non-western backgrounds. Recognizing the need for dedicated support, I sought permission to establish an outpatient clinic with dual objectives of: 1) assisting patients and 2) enhancing healthcare professionals' competence in treating non-western patients. The initiative

garnered support from politicians, leading to the opening of similar migrant outpatient units in Copenhagen and Aarhus. The migrant health clinic has since become a vital sanctuary within the Danish healthcare system.

Saira: *So, these are outpatient clinics as you mentioned. Do you also collaborate with family doctors?*

Dr. Morten Sodemann: Yes, in Denmark, general practitioners or family doctors serve as the entry point to the healthcare system. Patients referred to us must meet specific criteria, including documentation of previous unsuccessful treatments. We only accept referrals from family doctors to ensure their involvement and accountability for any treatment delays due to underutilization of available resources, such as interpreters. While family doctors typically allocate 15-20 minutes per consultation, MHC consultants dedicate 1-2 hours to each patient, compiling a comprehensive medical history, problem list, family tree, and life story documentation.

Saira: *Are there specific patient demographics at the MHC, such as ethnicity or age?*

Dr. Morten Sodemann: We see all kinds of patients and of all ages, however, the median age is about 44 years and about 65 % are women, I think. Many of our patients are those commonly referred to as "heart-sink" patients, indicating prolonged contacts with doctors and specialists without resolution. The first patients we saw were migrants and refugees from Burma and Bosnia, who had been living in Denmark for 15 years on average. Sixty-five per cent of them clearly had severe war related trauma that hadn't been acknowledged. Later, came waves of Syrian, Ethiopian Eritrean and Afghani refugees following wars and conflicts in those countries. However, patient waves do not coincide with different conflicts around the globe. It is more a geographical pattern and ethnic group pattern. Once awareness spreads within a particular ethnic group, they actively seek referrals to our clinic, expressing a desire for our specialized assistance.

Saira: *Do patients typically come alone or accompanied?*

Dr. Morten Sodemann: Initially, patients often arrive with a relative due to concerns about interpreter availability. However, we always provide interpreters, even for bilingual patients, recognizing that the bilingual brain fatigues after 20 minutes. Early on, we observed that even proficient bilingual patients and their accompanying relatives disengage from conversations after some time. Once bilingual relatives learn about our interpreter services, they feel relieved knowing they don't have to take off from their work and other commitments to accompany the patient to translate for them.

Saira: *Apart from training healthcare professionals, do you collaborate with universities like the Medical University to influence their curriculum? When my son was born, he showed signs of*

jaundice, so I took him to the emergency room on the sixth day when I encountered extreme difficulty waking him to feed. The emergency doctor on duty mentioned that it was difficult to diagnose jaundice based on the colour of his skin, but he admitted us to the paediatric unit. However, I found this response rather strange coming from a doctor

Dr. Morten Sodemann: This is an intriguing subject. The UK, owing to its colonial history, has a longer experience working with migrants from various countries compared to Denmark. The landscape in Denmark has recently undergone significant changes. Bilingual students are only now emerging in universities and raising questions. A recent Danish public study interviewed medical students about their representation in textbooks. People of colour are notably absent from medical textbooks. So, when it comes to conditions like jaundice and other serious illness which are visible on the skin, how do medical students diagnose them in individuals with darker skin tones? None of the medical students knew how to respond. In contrast to the UK, the focus on such issues in Denmark is relatively new. Additionally, when considering what is acceptable in Islam regarding modern treatments, many uncertainties arise. Imams in Denmark are often uneducated, lacking even basic schooling, and are ignorant of these issues. In such cases, healthcare professionals seek guidance from Muslim doctors in the UK or organizations providing relevant guidelines. Over our 15-year existence, our methodology has become integrated into the medical and nursing training curriculum at MHC. We are proud to note that our graduates entering clinical roles demonstrate different attitudes and communication patterns within our region.

Saira: *What has been your experience during COVID, especially concerning the impact on Muslim migrants?*

Dr. Morten Sodemann: So, quite early in the pandemic, we decided to reach out to our patients via phone since they were unable to visit the clinic during the lockdown. Our patients were extremely appreciative of these calls as they felt isolated and excluded. They struggled to comprehend the emergency measures imposed, which reminded them of the situations they had fled from. The sight of empty streets and shops, coupled with the stern demeanour of the Prime Minister and police chief on TV, added to their distress. Many patients were stranded with young children who lacked the necessary computers and laptops for online schooling thus, exacerbating their challenges. Recognizing the language barriers faced by ethnic groups, I organized a public medical translation service in our region. Engaging bilingual medical doctors, we translated information from Danish health authorities into 12 languages, disseminating it through WhatsApp and Facebook messages. This initiative gained significant traction, with the information being shared 100,000 times. Despite initial resistance from authorities, we persisted in advocating for translation services. Subsequently,

with the informal consent of Danish health authorities, a COVID-19 hotline was established in collaboration with the student organization, MINO Denmark, providing real-time translation services to callers in their native languages. Later, the Danish Refugee Council (DRC), assumed responsibility for the hotline, operating it as an NGO with online access to telephone advisors. Recognizing specific challenges in socially deprived areas with high immigrant populations, we also liaised with housing boards in the cities of Aarhus and Copenhagen to distribute multilingual information door-to-door. In one area, facing public scrutiny for high infection rates and low testing rates, our teams distributed T-shirts emblazoned with "best in test," encouraging residents to undergo frequent testing. Our efforts also extended to dispelling misconceptions about the vaccination. We conducted surveys to identify common misconceptions and produced videos featuring bilingual doctors and respected community interpreters, which were shared on social media platforms. This approach was also later adapted to create videos promoting screening for cervical and breast cancer.

Saira: *My PhD focuses on elderly Muslim migrants facing terminal illness during COVID-19. Can you share any related experiences?*

Dr. Morten Sodemann: We encountered a significant increase in long-term hospitalizations, a phenomenon unseen in the past six decades. Previously, patients might stay in the hospital for three weeks, but it became exceedingly rare for anyone to remain hospitalized for six weeks. This situation posed challenges for healthcare providers who were unprepared for such prolonged stays. Additionally, prolonged exposure of such patients with hospital staff fully clad in protective gear at all times, with only their eyes visible, had a profound impact on their mental well-being, inducing near psychosis. Previous research in other epidemics has shown similar effects on patients' mental health. Patients expressed a strong need for human contact and interaction, resorting to digital platforms like Facetime and WhatsApp video to connect with their families round the clock. However, this reliance on technology created tensions between patients and healthcare professionals, who initially resisted being monitored or overheard during patient interactions. Patients however, felt compelled to use such social media devices for the purpose of interpretation due to language barriers and the absence of interpreters. Additionally, for patients in isolation and quarantine, doctors and nurses had to grapple with the realization that the patients were cut off from normal human interaction and so needed continuous access to their families online. It took time for healthcare professionals to recognize the necessity of maintaining patient-family contact. Furthermore, some patients were admitted to intensive care units (ICUs), where the environment and procedures differed significantly from regular clinical wards, leading to challenges in communication and comprehension. This was especially the case for patients on life support machines who also sadly, succumbed to COVID-19. Even highly educated, bilingual engineers and doctors struggled to find the words to explain these

complex medical interventions to patients' families. This highlighted fundamental communication gaps in intensive care settings and the inherent limitations of hospital environments in addressing certain aspects of patient care. So, it was a new and quite significant experience for me learning there are things we just can't explain, and we don't have a solution for that.

Saira: *Finally, what are your thoughts on palliative care and palliative sedation for terminally ill patients compared to a natural death?*

Dr. Morten Sodemann: This is a clinical skill that is acquired with years of experience and requires a collaborated team effort. It is a collective way of looking at death in a setting which is not normal but, as close to normal. The debate surrounding active death poses a significant challenge to the medical community in Denmark. We frequently engage in end-of-life discussions across cultures and find palliative teams invaluable, not only in managing pain but also in addressing grief and loss. These teams offer a unique competence in navigating conversations about dying and grief. Understanding what constitutes a "good death" varies between countries and cultures, presenting an evolving field of study. Palliative care extends beyond medication, focusing on communication and understanding patient preferences. A patient that told me once, *" I don't want to die in a language that I don't speak*". Many people prepare for an afterlife and believe it is better to die well than be alive in hell with pain and needless struggles. That is a different way of talking about death than most ethnic Danes are used to. So, a language of dying is what we need to develop together and co-create a good, dignified death, acknowledging diverse beliefs and traditions. That is what palliative care really is about in my opinion. I give a lot of talks on the topic. It is not easy because some of the issues are the same as the life support machines, it is very difficult to find the right language for it

A special thank you to Dr. Morten Sodemann for participating in this interview and contributing to my research project.

Blog post by Saira Latif Mian, University of Hull Doctoral candidate for PhD Human Geography

Further Resources:

Dr Morten Sodemann's research profile is here https://portal.findresearcher.sdu.dk/en/persons/msodemann

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