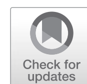

8 Case Study: Perceived Cultural Discord and Possible Discrimination Involving a Moroccan Truck Driver in Italy

Alessandro Stievano, Gennaro Rocco, and Giordano Cotichelli

Ahmed is a 40-year-old Moroccan truck driver who has been working in Italy for the last 13 years. Ahmed has a basic level of education and a sufficient conversational skill in the Italian language. Ahmed lives alone, and although is married with two children, his wife and children were left behind in Morocco. He is also financially accountable for his visually disabled younger brother who lives in Morocco. Ahmed, being the sole breadwinner, relies on his truck driving job to support himself, his immediate family, and his brother's family (Pfau-Effinger 2004).

Ahmed travels back to Morocco a couple of times year where he is often greeted with joy and gratitude for the financial support he offers. Ahmed wishes that one day, once he is financially capable, he could return to Morocco; however, as an added security option, he is also pursuing steps to acquire Italian citizenship. Given his truck driving occupation, Ahmed did not have opportunities to develop strong ties with the local Moroccan immigrant community in his town of residence in the Northern Italy. His connection to the community was through sporadic contacts with the local imam (religious clerk).

A few months ago, Ahmed started to experience and complained of severe acute back pain. Over time his pain became more frequent and more intense. One night he was obliged to rush to the accident and emergency room where he was visited by an orthopedic surgeon who advised him to have a series of examinations to rule out spondyloarthrosis. He prescribed a therapy with nonsteroidal anti-inflammatory drugs and suggested that he take time off work to rest and heal. The physician also advised him to modify his work duties and refrain from continuing as a truck driver.

8.1 Cultural Issues

As was recommended by the treating physician, Ahmed took 2 weeks off work to rest and to receive anti-inflammatory injection to relieve his pain. However, he refrained from seeking further diagnostic testing as ordered by the accident and emergency room physician. The truck company proprietor was very sympathetic with his condition and allowed Ahmed to modify his work duties by offering him an office position as an accountant. While Ahmed appreciated his boss's accommodation, he nonetheless was worried that

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his income would be impacted. His very reason for being in Italy and away from his family is that they depended on his ability to generate income to sustain himself and his family.

While receiving injection therapy in a nursing-run outpatient clinic, Ahmed resisted the nurse's effort to help him adhere to the treating physician's order for further diagnostic tests. He did not engage in the nurse's therapeutic care plan, and at some point during the course of treatment, he became belligerent and argumentative. He shifted blame for not getting better on the dysfunctional bureaucratic system.

Efforts toward establishing and building a therapeutic relationship with Ahmed came to a halt when his demeanor became verbally aggressive with the nursing staff. The result of this harsh conversation was a further worsening of an already degraded relationship with the nursing staff. Ahmed, at a certain point to avoid possible debates with the healthcare team, declared that he would be better off if he received the injections from a fellow countryman who had studied medicine in Morocco. He also was against having an orthopedic consultation and possible diagnostic workup for fear that a potential orthopedic diagnosis may declare him unfit, potentially losing his truck driving job. He was also scared of losing the right to ask for Italian citizenship.

Ahmed's physical health worsened due to his excessive use of steroidal anti-inflammatory drugs—drugs for which Ahmed experienced gastric discomfort—although he was verbally informed about possible gastric complications by the orthopedic surgeon in the accident and emergency room. Despite the fact that Ahmed had an adequate command of the Italian language, during one of his visits to the outpatient department, he was not able to make himself fully understood and explain the pain he felt in direct relation to gastric symptomatology.

The attending nurse also ignored his complaints because she was convinced that it was just another excuse to keep him on the anti-inflammatory injection therapy. Ahmed perceived the nurse's lack of attention to his complaints based on prejudice and racism. He was justifying his attitude on his overall perception of narrow-mindedness against people who were coming from the Maghreb region in Morocco. However, some nurses working in the clinic had concerns and doubted that Ahmed was "another of those North Africans" who did not feel like having a burdensome and onerous job and that he longed for having the nonsteroidal anti-inflammatory drugs just to receive some more time off work.

8.2 Cultural Issues

To study the global movements of people is a health priority in the globalized world (Tschudin and Davis 2008). The mass inflow of immigrants and refugees to Italy is very complicated and goes beyond traditional migration theories of push-and-pull factors (Prescott and Nichter 2014). In fact, the interconnections of political and economic reasons that are at the ground of the migratory processes to Italy ought to be analyzed through the lens of the ever-changing global trajectories (Stievano et al. 2017). Despite the 2008 economic recession, Italy is a country that hosts a high number of immigrants: 5,200,000 (Idos Migrantes 2016). Italy is Europe's main gateway for asylum-seekers from Africa. Although most of those asylum-seekers are rescued during the journey from the North African coasts to the Southern Italy shores, a large percentage of these refugees end up being homeless in Italy and in other European nations due to the lack of supportive systems. Italy is home to immigrant from North African and Eastern European countries. Romanian immigrants form the largest group (1,131,839, 22.9%), followed by Moroccans (510,450, 13%), Albanians (490,483, 9.3%), Chinese (265,820, 5.4%), and Ukrainians (226,060, 4.6%). Other immigrants are from the Philippines 3.3%, India 3.0%, Moldova 2.8%, Bangladesh 2.4%, and Egypt 2.2% (Idos Migrantes 2016). Hence, Moroccans are the second largest immigrant community in Italy and represent one of the most important countries in the Maghreb area. Nowadays, the migration from Morocco to Italy is one of the longest and largest migrations in Europe, and Moroccans who are present in Italy in 2016 were

510,450 which is equal to 13% of the non-European residents in Italy (Ministry of Work and Social Welfare 2016).

There is no doubt that the continuous influx of immigrants is taxing the Italian systems, especially the housing and the healthcare system. The Italian society is reeling the brunt of immigrant groups who do not know or adhere to the local norms or abide the laws. Current security concerns in Italy and worldwide may heighten stereotypes and may have an impact on the nature of care that is offered or perceived. Adding to the already held negative attitude that Moroccans tend to avoid hard work, the potential for non-culturally responsive healthcare encounters is very high.

After having delineated the cultural setting where this case had taken place, some considerations must to be highlighted. Ahmed's impetus for coming to Italy is similar to those of his compatriots—the search for economic opportunities with higher pay and better working conditions (Correia et al. 2015). Ahmed came seeking work in Italy in order to provide not only for his own immediate family but also for his extended family. In the eyes of his family, he is the beacon of hope and the anchor for their survival and potential progress. This conceptual mindset is possibly the source of anxiety and uncertainty for Ahmed because, as his health is worsened, he is likely to fail in meeting the financial obligation toward his family.

Ahmed's possible avoidance of seeking further orthopedic consultation may be based on his fear of being labeled inept or disabled and as such limit his chances to continue with his truck driving job. Ahmed is also frightened to seek help from his fellow citizens and from the spiritual guide of his community, the Imam, because he fears he could be seen as a fragile man. He is also worried that his dignity and reputation as a strong man who is looked up to may be tarnished.

8.3 Culturally Competent Strategies Recommended

In healthcare settings with cross-cultural encounters such as the case of Ahmed, the knowledge and skills of the healthcare provider demand not only knowledge and skills of the client culture and the societal stigma associated with the client's background but, as in this situation, require the reflective unpacking and evaluation of the client's personnel trials and tribulation and his or her real or perceived threats of discrimination due to racism. As a strategy, healthcare providers must consider multidimensional assessment and intervention approaches.

8.3.1 Individual-/Family-Level Interventions

- Assessment must include external forces impacting the person and the available coping resources.
- Assessment and intervention strategies of the contextual variables impacting the cross-cultural health encounter include the organizational and socio-structural levels of interventions to meet the healthcare needs of persons similar to Ahmed's.
- Consideration of the geopolitical forces and their impact on the host society and on the individual immigrant is increasingly important in ensuring fair treatment.
- Offering interprofessional case studies and educational lectures/seminars to enhance healthcare providers' understanding of intersecting cross cultural variables that can potentially affect the healthcare outcomes of persons similar to Ahmed's.
- Attention should be paid to repairing and rebuilding the therapeutic relationship between Ahmed and the nursing staff through intentional and focused communication and problem-solving among the healthcare providers and through a culturally responsive care plan (Bergum and Dossetor 2005).

8.3.2 Organizational-Level Interventions

- Establish specific policies and procedures focused on the care of vulnerable and underserved immigrant populations with a special

emphasis on social determinant variables such as gender, age, ethnic and religious backgrounds, and cultural beliefs and values.
- Supportive health organization's resources are required to assist healthcare providers in delivering culturally responsive healthcare.
- Offer ongoing training and education toward culturally responsive and congruent care and language and cultural interpretive services.

8.3.3 Community-/Societal-Level Interventions

- An enhanced evaluation of the influxes of immigrants is the first step to carry out a personalized cultural congruent plan of care (Douglas et al. 2014).
- Know the diverse habits of the main ethnic groups and provide information that healthcare providers should consider in order to have a stronger connection with the North African community.
- Involve social care networks to provide a better link with the North African community to assist in improving the understanding of Ahmed's social and economic concerns by healthcare providers.
- Social work professionals should strategically connect Ahmed with his community and with a religious guide to provide advice, support, and resources.

Conclusion

Ahmed's clinical case represents a common health situation in Italy where the culture, organizations, and professionals intersect to produce unwarranted negative health encounters for both the patient and the healthcare provider. Offering quality, cost-effective, and culturally responsive healthcare outcomes requires knowledge and skills on the part of healthcare providers, supportive resources on the part of the healthcare organizations, and culturally responsive community resources.

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