

**What Matters to Patients and Physicians in Their Cross-
Cultural Clinical Encounters: An Ethnographic Study
and a Medical Ethics Perspective**

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Written Declaration

I declare that I have written this dissertation

“What Matters to Patients and Physicians in Their Cross-Cultural Clinical Encounters: An Ethnographic Study and a Medical Ethics Perspective”

with only the aid specified therein and that I have not submitted it to any other university or to any other faculty of the University of Basel.

Basel, October 2018

(Signature)

Content

<i>Written Declaration</i>	2
<i>Figures and Tables</i>	4
<i>Acknowledgement</i>	5
<i>Abstract</i>	7
<i>I. Introduction</i>	9
1. Background	9
1.1. Communication and interaction in cross-cultural clinical encounters	11
1.2 Ethical topics in migrant health	13
1.3 Perspectives of migrant patients and physicians at the level of their individual encounter	15
2. Objectives and aims of this dissertation	15
3. Study design and methods	16
3.1 Design and participants	16
3.2. Data Collection	17
3.3 Qualitative data analysis	17
<i>II. Published articles</i>	19
Article 1	19
Article 2	26
Article 3	49
<i>III. Discussion</i>	76
1. Overview of main findings	76
2. Summary Discussion	79
3. Strengths and weaknesses of this research	87
<i>IV. Conclusion</i>	90
<i>V. Publication bibliography</i>	93
<i>Appendices</i>	108
<i>Curriculum Vitae</i>	120

Abbreviations

EKNZ	Ethikkommission Nordwest- und Zentralschweiz
FOPH	Federal Office of Public Health
HCP	Healthcare professional
LEG	Low German Proficiency
LEP	Low English Proficiency
MOC	Medical Outpatient Clinic
NCE	Swiss National Advisory Commission on Biomedical Ethics
USB	University Hospital Basel
WOC	Women's Outpatient Clinic

Figures and Tables

	Title	Page	Chapter
Figure 1	'Table 1: Data sources'	31	Published articles (Article 2)
Figure 2	'List of patients and doctors who were interviewed'	54,55	Published articles (Article 3)

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Abstract

Given the current increase of global migration movements and its implications for healthcare systems (Carballo et al. 2017), it is important to better understand how patients with migration background and healthcare professionals experience their shared clinical encounters and the specific factors that can influence communication and interaction between them. Here, reflections on 'culture' and biases as well as the topics of language barriers and mutually perceived problem areas have proved to be fruitful. Furthermore ethical aspects surrounding the perceived issues have to be explored. If not addressed, language barriers can affect communication and interaction in cross-cultural clinical encounters and quality of care negatively. Although the need to address language barriers is widely acknowledged, little is known about how linguistic complexities shape decision-making for or against the use of interpreter services in everyday cross-cultural encounters. Also, it is crucial to explore the problem areas patients with migration background and healthcare professionals identify, and to reflect connected ethical aspects. **Using an ethnographic approach**, 32 migrant patients (16 of Albanian and Turkish origin, respectively) have been accompanied during their medical encounters at two outpatient clinics (using participant observation and semi-structured interviews with patients and healthcare professionals). Overall, 94 interviews with patients and healthcare professionals on how they perceived communication and interaction in their cross-cultural clinical encounter were conducted. Perspectives of patients and physicians on their shared clinical encounters were triangulated regarding the topics 'getting-by with limited language proficiency' as well as 'difficulties and challenges'. In one case a patient's, a physician's and the researcher's perspective have been compared. **Results show** that reflecting on 'culture'

and one's own biases is an essential tool promoting insights about what can be relevant in a cross-cultural clinical encounter. In the context of language barriers, the assessment of the language situation, the involvement of interpreters, and dealing with conversational limits are important topics to physicians and patients shaping decision-making for or against the use of interpreter services. Furthermore, patients and physicians identified the topics of 'patient behaviour in relation to doctors' advice' and 'relationship issues' as meaningful problem areas in their encounters. What makes perceived issues relevant from a medical ethics perspective is that potential ethical implications of perceived difficulties (e.g. regarding how shared decision-making can be made in the context of relationship issues or questions of responsibility in the context of the social embeddedness of health) were not identified during clinical routine.

A deeper understanding of cross-cultural clinical encounters and ethical aspects of everyday cross-cultural clinical routine is provided by presenting patients' and physicians' perspectives on their shared encounters focusing on the interplay between 'culture', stance and biases, the complexities of decision-making in the context of language barriers and difficulties and challenges that can arise in cross-cultural settings.

I. Introduction

1. Background

Migrant health remains an urgent topic in numerous societies since decades (Mladovsky et al. 2012; Rechel et al. 2013). Along with a general, global increase, migration movements have become more rapid and diverse in itself, e.g. regarding migrants' national and linguistic backgrounds, sociodemographic aspects or migration histories (Meissner and Vertovec 2015; Vertovec 2007). These societal developments are reflected within healthcare settings where communication and interaction in clinical encounters are increasingly shaped by linguistic, cultural, social and ethnic "complexities" (Vertovec 2007).

Also in Switzerland, esp. in the canton of Basel-City, the increase in the proportion of foreigners over the past decades (Bundesamt für Statistik 2017b) has been accompanied by a diversification of the foreign population itself (Statistisches Amt Basel-Stadt 2018). At the University Hospital Basel (USB) this rapid and complex social change is mirrored in both patient populations and hospital staff. For example, hospital figures show that in 2011 35.6% of outpatients and 43% of hospital employees were 'non-Swiss'. Diversification is also reflected in the USB's interpreter service, whose language offer has increased over the past decades accordingly.

Despite its heterogeneity in nationalities, sociodemographic and other characteristics, in Switzerland, migrants are overrepresented at the lower end of the socioeconomic spectrum of

society. For example, compared to the population without migration background¹, migrants more often work in the low-wage sector, they are more affected by poverty or, in general, they more often lack post-compulsory schooling (Federal Statistical Office FSO 2015, 2018; Bundesamt für Statistik 2017a). The social embeddedness of health is impressively shown by the effects of income, employment and health education, areas which are among the “core dimensions of social inequalities” (Richter and Hurrelmann 2009; Marmot et al. 2012). Thus, having a migration background is going along with increased risks to experience disadvantages regarding health and healthcare provision (Malmusi, Borrell et al. 2010, Bundesamt für Gesundheit 2012).

Research has provided much evidence on health (-related) inequalities across diverse societal minority groups within many societies. Links between patients’ origin and providers’ decision-making in diagnostics and treatment have been shown widely, e.g. in pain treatment (Shah et al. 2015; Hirsh et al. 2015; Burgess et al. 2006), in the context of chronic conditions as well as in cardiovascular disease (Heisler et al. 2003; Ibrahim et al. 2003) or in mental health (Adams et al. 2014; Cook et al. 2016). Moreover, differences in health outcomes between migrants and non-migrants have repeatedly been revealed, for example in healthy life expectancy among older migrants and non-migrants (Reus-Pons et al. 2017), occupational diseases, and maternal mortality rates (Reus-Pons et al. 2017; Bundesamt für Gesundheit 2012; BAG 2013). Also regarding access to care and use of (preventive) healthcare services differences between diverse

¹ The term population with a migration background as defined by the Federal Statistical Office (FSO) “includes all foreign nationals, naturalised Swiss citizens, except for those born in Switzerland and whose parents were both born in Switzerland, as well as Swiss citizens at birth whose parents were both born abroad”.(Bundesamt für Statistik: <https://www.bfs.admin.ch/bfs/en/home/statistics/population/migration-integration/by-migration-status.html>)

migrants and non-migrants have been published (Woodward et al. 2014; Mantwill and Schulz 2017; Fontana and Bischoff 2008).

1.1. Communication and interaction in cross-cultural clinical encounters

Compared to the group level where relevance is generally determined by numbers, the clinical encounter is a micro world. Yet, the clinical encounter is that key situation in which immediate interaction between healthcare professionals and patients takes place, “the ‘atom’ and indivisible unit of any form of healthcare delivery” (Schattner 2014). In cross-cultural clinical encounters, there are specific factors that can influence and/ or challenge communication and interaction between patients and healthcare professionals.

Language barriers and use of interpreter services

The topic of language (proficiency) is among the key issues in cross-cultural clinical encounters. If not addressed, language barriers can negatively impact quality of care and patient safety (Diamond et al. 2009; Wilson 2013; Flores 2005; Flores et al. 2005). However, it has been shown that even if medical interpreter services are available, physicians tend to underuse them and “get by” with patients’ limited language skills (Diamond et al. 2009; Bischoff and Hudelson 2010; Steinberg et al. 2016). During daily clinical routine, decision-making for or against using an interpreter can be driven by competing demands such as “time constraints, alliances of care, therapeutic objectives and organizational-level considerations” (Hsieh 2015; Steinberg et al. 2016). Additionally, existing directives, such as the internal USB-guideline², usually focus on procedures *after* the need for an interpreter has somehow been acknowledged (e.g. when to use

² See appendices

which type of interpreter service), be it by healthcare professionals or patients themselves. Yet, little is known about what happens *before* this decisive moment, namely if or how decision-making takes place, for example which criteria are driving decisions when dealing with limited language proficiency.

Culture(s) in healthcare

‘Culture’ is another critical topic in the field of migrant health. Throughout history, the discourse on the term ‘culture’ has developed in many stages across geographic regions and disciplines, leading to a wide range of theories and conceptions on ‘culture’ today (Moebius and Quadflieg 2011). As the term ‘culture’ is subject to scientific consideration and simultaneously an integral part of everyday language, *concepts* of ‘culture’, as in social- and cultural anthropology (mostly having a theoretical constructivist underpinning) and *understanding* or *use* of the term ‘culture’ in the public sphere such as in medical institutions and clinical practice, differ heavily. There is agreement that a narrow and unreflective use of the term ‘culture’ in medicine, e.g. as a synonym for nationality or as a set of general attributes characterizing someone from a given background, can reinforce prejudices and stereotyping and, thus, should be avoided (Napier et al. 2014; Knipper 2014). Nevertheless, it has been shown that vague and static cultural concepts, which “reduce individual behaviour to broad stereotypical formulas, or at least encourage such stereotyping,” (Napier, Ancarno et al. 2014) are still often to be observed in the medical context (Kleinman and Benson 2006, Napier, Ancarno et al. 2014). Yet, beyond theoretical debates about how ‘culture’ should be conceptualized, there is no doubt that ‘culture’ is expressed in communication and interaction. Therewith especially in health and healthcare, where good communication is decisive, there is a need for both, to engage with the term ‘culture’ and

address the connected issues in clinical practice (Betancourt et al. 2005; Carrillo et al. 1999; Kleinman and Benson 2006).

Carrillo et al. (1999) define core cultural issues as “situations, interactions, and behaviours that have potential for cross-cultural misunderstanding” which ‘often reflect a difference in culturally determined values’ as, for example, relating to physical contact, communication styles, gender, sexuality, and family’ (Carrillo et al. 1999). Another example is Domenig’s approach of ‘transcultural competency’ (Domenig 2007) which clearly emphasizes that the focus has to be directed to interactions and the relationship between the patient and the healthcare professional instead of focusing a patient’s ‘foreign culture’. This textbook which includes theoretical considerations on culture, conceptualizes ‘transcultural competency’ as the triad of narrative empathy, self-reflection and background knowledge (Domenig 2007). However, in recent criticism on competence it has been argued that ‘the complex nuances of difference’ cannot be just mastered so easily as the term competence might suggest. In contrast to such understanding which is primarily concerned with ‘mastering the Other’, rather than examining the internal cultures, prejudices, fears, or identifications of the Self in relation to that ‘Other’ the idea of (narrative) humility examines and emphasizes the significance of one’s own stance towards a patient rather than simply mastering a set of skills (DasGupta 2008).

1.2 Ethical topics in migrant health

At macro level, medical ethics’ interest has particularly focused on inequity and connected aspects (e.g. discrimination, unfairness, under-care) which affect migrant patients in health and healthcare provision, for example when resources are allocated unequally as shown by Hurst et

al. (2007) or regarding the right to health, as in the context of the use of and access to interpreter services (NEK CNE 2017).

However, at micro level, ethical evaluation of cross-cultural clinical encounters has focused on ethical problems in different areas largely referring to a principles-based approach, for example in the context of perceived difference in culture, beliefs or values as well as in communication through interpreters (Björn 2005; Ilkilic 2007).

In view of social determinants of health inequalities, some medical ethics' approaches were criticized for promoting an individualistic perspective on health placing the individual's responsibility for his/ her own health in the centre (Ahola-Launonen 2015). Thus, a call for medical ethics to take the social perspective more into account by including the 'broad social and cultural context within which medicine and individuals exist' was articulated (Ahola-Launonen 2015). This is in line with the great effort made to move medical ethics towards public health ethics or even global ethics (Have 2011).

Yet, beyond ethical problems becoming accessible through the explicit articulation of an ethical problem- at micro or macro level, little is known about the ethical aspects evolving from unspectacular daily clinical routine of cross-cultural clinical encounters. The field of ordinary clinical practice in general has been addressed by Komesaroff (1995) and others (Truog et al. 2015; Zizzo et al. 2016) arguing that not only the 'dramatic ethical issues' (Zizzo et al. 2016) bear an ethical dimension, but also 'those clinical decisions which at first sight appear to be the simplest and most straightforward' (Komesaroff 1995). However, grave ethical issues in healthcare can teach those involved to identify also more subtle (and frequent) ethical challenges arising in this realm and sensitize healthcare professionals and ethicists.

1.3 Perspectives of migrant patients and physicians at the level of their individual encounter

Patients' and healthcare professionals' perspectives on their shared clinical encounters have been studied earlier, for example in different clinical areas or in diagnosis-related patient groups (e.g. semi-structured interviews, observational data) (Bugge, Entwistle et al. 2006, Salmon, Mendick et al. 2010). However, their perspectives on their shared encounters have rarely been assessed and compared, regarding the topics of language and culture, difficulties or other aspects.

Yet, in the context of migrant health, where stereotype and prejudice are a constant threat and where conditions of communication and interaction can be difficult due to differences in language or background, it is particularly important to look at the micro-level of providers' and patients' experiences by investigating *their* authentic views.

2. Objectives and aims of this dissertation

This dissertation was implemented within the context of the Federal Office of Public Health's (FOPH) "Programm Migration und Gesundheit (2002-2017)" and the USB program on "Diversity Management"³. Based on the variety of issues existing in migrant health and research gaps mentioned in the previous text sections, this PhD project aimed to open up the view to the micro-level of individual cross-cultural clinical encounters. Its objective was to find out how patients with migration background and physicians themselves perceive their daily clinical encounters and what was relevant to *them*.

³ Former project "Gesundheit und Migration: Diversität und Chancengleichheit am Universitätsspital Basel"

The main research question of this thesis was:

How do migrant patients and hospital staff members experience their shared clinical encounters across language and culture throughout a patient's entire hospital stay, from arrival to departure?

- Are there specific issues besides core cultural aspects (Carrillo et al. 1999), which influence their communication and interaction?
- Which aspects have to be considered from a medical ethics' perspective?

3. Study design and methods

3.1 Design and participants

This PhD study used an ethnographic research methodology. It included different data sources (semi-structured interviewing, observation), different groups of participants (migrant patients and healthcare professionals) and used different techniques of data analysis (summarizing content analysis, triangulation). The process of accompanying patients during clinical encounters with hospital staff and interviewing both afterwards about their respective perceptions of the encounter, built the core of the study procedure. Thirty-two outpatients of Turkish and of Albanian origin were included in the PhD study. This choice was based on USB statistics on outpatients in 2009: after the Swiss, patients of Turkish nationality formed the largest group, followed by German and Italian nationals. Patients from countries of former Yugoslavia formed the fourth largest outpatient group. At the same time, there was a high share of interpreting services, called in for patients from Turkey and patients speaking Albanian (coming from different political entities, namely from Kosovo, Montenegro, and Macedonia).

3.2. Data Collection

The study was conducted at two outpatient departments (OPD) of the USB. Participant observations were carried out during clinical encounters of patients and healthcare professionals (passive participation) and during long-time presence at both OPDs (e.g. front desk procedures) and informal talks with staff and patients were conducted. An observational grid served as a research instrument and for pre-structuring observations (Carrillo et al. 1999; Pope 2005; Huby et al. 2007; Holloway I 1997). It included aspects of verbal (e.g. conversation content, contribution to conversation), and non-verbal communication (e.g. mimicry, bearing) as well as interaction sequences according to social (e.g. educational background) or culture-associated factors (e.g. regarding physical contact, gender).

Ninety-four semi-structured interviews with patients and staff members were conducted. Interviews lasted up to 90 minutes, were tape-recorded and transcribed verbatim. Each interview covered sections on demographics, cultural and social aspects, language and communication and contained two types of questions: First, specific, pre-defined questions deriving from the literature and the experience of two practicing physicians in the research team (SCH, WL). Second, questions relating to observations made during the clinical encounter under examination. The interview guide was pilot tested during five interviews and revised accordingly.

3.3 Qualitative data analysis

Semi-structured interviews were analysed in several cycles by inductive formation of categories. Codes and sub-codes were developed inductively. Coded sections of patients' and physicians' interviews were compared, and codes were collated where appropriate (triangulation).

Categories which were overlapping between patients and healthcare professionals were further analysed in depth.

In one case, significant overlapping between categories, in terms of consistency between the patient's and the physician's perspectives, led to an in-depth analysis in which the researcher's (observational) perspective was triangulated with the patient's and the physician's interview data (Article 1). Two further overarching categories were generally found overlapping between patients and physicians: the category of 'insecure language' (Article 2) and 'difficulties and challenges' (Article 3).

II. Published articles

Article 1

K. Würth, S. Schuster, **“Some of them shut the door with a single word, but she was different”**

– **A migrant patient’s culture, a physician’s narrative humility and a researcher’s bias.** PEC 100 (2017) 1772-1773.

She stood in the entrance hall of the women’s outpatient clinic waiting for me with a friendly smile: Mrs. A., a 50-year old patient of Albanian origin who had agreed to participate in my ethnographic study. Today, I would observe her consultation with the physician and interview both of them afterwards. But first, we passed the front desk and sat down together in the waiting area. As so often, I felt slightly uneasy about the situation – my being a medical anthropologist and researcher, and her being a ‘migrant patient’ and the ‘object’ of my research. Since her German was not reliable, I was also uncertain whether she truly understood what was said.

As a medical anthropologist, I do not see hospitals as being different from real life or the ‘outside’ world. Permeated by a given society and its local culture, they mirror societal processes in a condensed way [1]. Moreover, the cultural, linguistic and ethnic diversity of contemporary societies is reproduced within healthcare institutions and individual clinical encounters. While ‘cultural competence’ has gained prominence in Switzerland, ‘cultural humility’ with its critical stance on ‘competence’, and ‘narrative humility’, which emphasizes one’s “own prejudices, expectations, and ‘frames of listening’” [2] are less well-known. Against this background and in

view of health disparities between the Swiss and migrant populations [3], my research focused on how migrant patients and hospital staff experience their common clinical encounters, and on what was relevant to each of them in their interactions.

Mrs. A.'s socio-demographic background matched the characteristics frequently associated with migrant patients – low local language proficiency, low education level and socio-economic status, several children and a husband of the same origin. I was somewhat surprised, yet relieved when her husband did not show up because I often felt uncertain about handling the potential power dynamics that could arise. Mrs. A. has been attending the women's hospital since she migrated to Switzerland in her twenties and said she felt very satisfied with it. I have come to expect that. Many patients reported satisfaction and I wondered whether it was because I was wearing the required white coat and being perceived as a hospital representative? Were they too polite to tell the truth or afraid of being honest? Either way, I found it hard to believe that they were always satisfied. I assumed that the language barriers, cultural and social differences were challenging for migrant patients and therefore, a potential source of dissatisfaction, frustration or disappointment.

While still waiting, I briefly recapitulated aspects of the grid developed for the participant observation: How would they communicate given her limited German proficiency? Which 'cultural core issues' [4] could come up? Where was there potential for possible misunderstanding? When I obtained the physician's consent to join the consultation, I learned that she was a woman and therefore concluded that the possible discomfort created by gender discordance within a gynecological encounter would not be an issue. The observational grid was drafted according to literature [4–7] and the knowledge of physicians experienced in cross-

20

cultural encounters. With my grid, medical anthropological experience and willingness to be attentive and open towards the three of us – patient, physician and myself – I was ready.

Finally, the door opened and we entered the consultation room. While Mrs. A. and Dr. M. took a seat, I grabbed a small stool and kept myself in the background. “How are you?” Dr. M. asked. To me, the way she voiced this simple and common question felt like opening up space for Mrs. A. I felt confirmed when she immediately began to narrate. She reported having abdominal pain and for that reason she had already consulted several specialists. She smiled a little. Dr. M. kept listening. Mrs. A. continued explaining that she often felt tired and did not work. Dr. M.’s facial expression appeared empathetic, I thought. “Do you also feel sad sometimes?” Dr. M. asked. “Yes”, Mrs. A. affirmed and added that for some time she often cried without knowing exactly why. “Sometimes, this can come from the soul”, Dr. M. said carefully. “How severe is this sadness?”, “do you sometimes think I would like to die?” she asked, digging deeper. This was a critical moment, I felt. The fact that Dr. M. used the term ‘soul’ instead of ‘psyche’ indicated to me her awareness that this might be a sensitive topic. I have repeatedly observed physicians hesitating to address mental health issues directly. Would Mrs. A. react with reserve? How would Dr. M. cope in that case?

To my astonishment, none of this happened. Mrs. A. stated that she didn’t want to commit suicide and revealed that her brother had recently passed away. Her voice became shaky and she silently cried a little. “Can you talk about this with someone?” Dr. M. asked compassionately. “Yes, with my sister”, Mrs. A. affirmed. Thereupon, Dr. M. referred to the option of professional help and asked whether she was interested in psychotherapy. Mrs. A. explained that she

preferred to try within her family first. She would consider the offer if necessary. The atmosphere during this conversation felt calm and relaxed despite its serious content.

Then Dr. M. turned to the original purpose of the consultation: the coil. The vocabulary became driven by medical terms, and Mrs. A. indicated her difficulties in understanding several times. Dr. M. tried to address these limitations using gestures, for example, fanning herself when asking about flashes. In addition, Dr. M. made a drawing to explain the myoma shown in the ultrasound but Mrs. A. still had a questioning gaze. Only after Dr. M. assured, “it is nothing serious”, did she appear relieved and showed no further interest in this subject.

Almost disappointed, I realized that little of what I expected had happened: So-called cultural issues were not obvious to discern and if so – like mental health –, they did not inevitably lead to difficulties. The same held true for the impact of Mrs. A.’s limited German proficiency. It touched me that despite the language barrier, their communication seemed easy. Questioned why no interpreter had been involved, Dr. M. replied she had not known about Mrs. A.’s limited German because she was seeing her for the first time.

After the consultation, I interviewed both separately about their experiences of the encounter. Their perspectives on the most important aspects of this consultation matched perfectly and revealed an intriguing insight into why this consultation proved my expectations wrong: Both felt that their mutual understanding was rooted in a sense of openness and cordiality they had in common. Trying to clarify what exactly Mrs. A. meant by openness she said glowingly “some of them shut the door with a single word, but she was different.” Seemingly, the physician’s attitude as reflected by her way of wording and listening created an atmosphere encouraging

the patient's narrative. This provided the space to speak about psychotherapy, one of my presumed potential sensitive issues. Although she was not interested, she appreciated that this topic was addressed. For her, it indicated that Dr. M. truly cared. Regarding the gynecological issues, both sensed that everything went well and conversational limitations due to the language barrier did not really matter. However, something else impressed both of them most, independently of one another. Dr. M. got to the heart of it by saying: "The coil became somewhat of a pretext but the really nice thing was this cordial contact we had."

Afterwards, I felt the need to reflect upon my own perceptions. I witnessed an encounter between a patient and a physician that turned out to be everything, except what I had foreseen. Despite being a researcher trained in anthropology, which implies both objectivity and cultural expertise, I was surprised to discover that among the three of us, I was the one with the preconceived ideas: inevitably associating cultural, socioeconomic and language differences with difficulties.

Reflecting on the clinical encounter, I realized how the physician had done well with her 'special kind of listening' [8] akin to narrative humility [9]. This term emphasizes the importance of listening, receptiveness and openness towards an unknown other and a patient's narrative [9]. Dr. M.'s stance and transparency allowed both actors to make real contact with each other, which proved to be crucial for their mutual understanding and negotiation of existing differences.

This experience revealed to me the compelling potential of narrative humility and why continual self-reflection is so important, particularly in cross-cultural encounters. My presumptions almost

barred my way to what was experienced as essential in this consultation: 'simply' a cordial contact. Discovering my own bias, mirrored through the stance of narrative humility showed me that researchers are no different. Becoming aware of own biases is an ongoing task that we all need to engage in regardless of one's profession, knowledge or role. What really matters, is taking a humble stance towards an other's culture and narrative as physician – and as researcher.

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Article 2

Würth KM, Reiter-Theil S, Langewitz W, Schuster S: "Getting by" in a Swiss Tertiary Hospital: the Inconspicuous Complexity of Decision-making Around Patients' Limited Language Proficiency. J Gen Intern Med. 2018 Aug 24. doi: 10.1007/s11606-018-4618-0. [Epub ahead of print]

Abstract

Background

While the need to address language barriers to provide quality care for all is generally accepted, little is known about the complexities of decision-making around patients' limited language proficiency in everyday clinical encounters.

Objective

To understand how linguistic complexities shape cross-cultural encounters by incorporating the perspective of both, patients and physicians.

Design

A qualitative hospital study with semi-structured interviews and participant- observation in a Swiss University Hospital. Thirty-two encounters were observed and 94 interviews conducted.

Participants

Sixteen patients of Turkish and 16 of Albanian origin and all actors (administration, nurses, physicians, if required, interpreters) involved in the patients' entire process.

Main Approach

Interviews were audio-recorded and transcribed verbatim. A thematic content analysis was conducted using MAXQDA. For reporting, the COREQ guidelines were used.

Key Results

Three themes were relevant to patients and physicians alike: Assessment of the language situation, the use of interpreters, and dealing with conversational limits. Physicians tend to assess patients' language proficiency by their body language, individual demeanor, or adequacy of responses to questions. Physicians use professional interpreters for "high-stakes" conversations, and "get by" through "low-stakes" topics by resorting to bilingual family members, for example. Patients are driven by factors like fearing costs or the wish to manage on their own. High acceptance of conversational limits by patients and physicians alike stands in stark contrast to the availability of interpreters.

Conclusions

The decision for or against interpreter use in the "real world" of clinical care is complex and shaped by small, frequently inconspicuous decisions with potential for suboptimal health care. Physicians occupy a key position in the decision-making to initiate the process of medical interpreting. The development and testing of a conceptual framework close to practice is crucial for guiding physicians' assessment of patients' language proficiency and their decision-making on the use of interpreting services.

Introduction

Physicians underuse medical interpreters despite readily available interpreting services. [1, 2, 3] They make decisions after weighing the benefits of accurate communication against competing demands such as “time constraints, alliances of care, therapeutic objectives and organizational-level considerations.” [3, 4] Although physicians often resort to professional interpreters for interactions that are complex or involve “high-stakes,” [1, 3] sometimes they find it easier to “get by” without one. Patients’ perspectives on interpreter use are rarely assessed. [5] This paper sheds light on the challenges physicians and patients face with patients’ limited language proficiency (LP) in everyday clinical encounters and reflects upon the factors which drive the seemingly simple, unspectacular decision for—or against—the use of professional medical interpreters within a Swiss tertiary hospital.

The contemporary “speed, scale and spread” [6] of international migration and the global refugee crisis place migration at the top of the political agenda in Switzerland and Europe. In the past 30 years in the German-speaking Swiss Canton of Basel-City, the foreign residential population has grown from 20.4 to 36% from 157 nations. These striking figures are reflected at the University Hospital Basel (USB), the canton’s main health care provider, where 36% of outpatients and 43% of hospital employees are “non-Swiss.” Therefore, the rapid and complex social change of contemporary societies is reproduced within health care institutions and individual clinical encounters, among and between patient populations and hospital staff. [7, 8, 9] Basel-City and the USB, currently have the most diverse populations ever, culturally, ethnically, and linguistically.

Language forms a key tool to organize and navigate diversity, as is the use of interpreting services to provide appropriate health care across language barriers. Since the introduction of the interpreter service at the USB 30 years ago, the number of languages expanded from one to over one hundred languages available on-site and over-the-phone today. The use of these external language services increased decisively with Turkish interpreters consistently the most common. But languages like Tigrinya are on the rise representing 9.2% of all interpreter requests today, while Eritreans represent only 1% of all “non-Swiss” patients. This provides insight into the changes that the hospital’s patient populations have undergone and the inherent growing linguistic complexities.

However, prior to using a medical interpreter, the need for one has to be acknowledged. This seemingly simple decision is complex and fraught with options and difficulties in the “real world” of clinical practice and may result in clinicians “getting by” [1, 4, 5] without one.

While in the USA, patients with limited English proficiency have a legal right to access health care in their preferred language, [12] this is not the case in Switzerland. Usually, advocates emphasize the need to address language barriers to avoid possible negative implications for quality of care and patient safety. [1, 3, 4, 5, 10] Access to health care as a human right as defined by the United Nations and World Health Organization is inextricably linked to appropriate language services. [11] Together with the recent statement by the Swiss National Advisory Commission on Biomedical Ethics¹ (NEK), they provide a valuable political instrument on a macro-level, although nonbinding. However, this “ideal” has to be transferred into the “real world” of clinical practice. Therefore, the micro-level of provider-patient interaction needs to be thoroughly considered and should be part of the inquiry. The micro-ethics approach by Komesaroff, [12] Truog, and

others [13, 14] focuses on the unspectacular “choices that arise in everyday clinical encounters.” [13] As Komesaroff states, “crucial ethical issues are involved [...] in those clinical decisions which at first sight appear to be the simplest and most straightforward.” [12] Data which relate the “ethical” with the “empirical” [15, 16] are of fundamental importance to reveal the inconspicuous complexity of decision-making around patients’ limited LP.

We conducted a qualitative study to examine how “migrant patients” and hospital staff experience shared communication and interaction across language and culture throughout the entire hospital process from patients’ arrival to departure.

Methods

The data presented are a subset of a larger study with a focus on how linguistic complexities shape the consultations of patients and physicians (primarily residents). The study was designed as hospital ethnography using semi-structured interviews, participant observation, and informal conversations conducted by the first author (KW). The research took place within the program on diversity management headed by the last author (SCH).

Patients were recruited from two main patient populations, 16 of Turkish² and 16 of Albanian³ origin, identified by their names on the clinic schedule and approached in the waiting area of two USB outpatient clinics. After introducing herself as a PhD student/Medical anthropologist (KW), patients were informed about the study and asked whether they agreed to participate if they had a follow-up appointment.

Ninety-four interviews were conducted between August 2012 and January 2015. Each patient interview was followed by interviews with all staff members that the patient had interacted with

30

(front desk staff, nurses, physicians, and interpreters when required) (Table 1). The interviews were conducted face-to-face after informed consent was received, and privacy and confidentiality assured. Interviews lasted a maximum of 1.5 h, were tape-recorded, and transcribed verbatim.

Table 1 Data sources		
	Patients of Albanian origin	Patients of Turkish origin
Number of patients:	16	16
Number of medical consultations observed:	16	16
Number of communication strategies used in observed medical consultations		
Professional interpreter:	3	3
Family members:	0	2
Bilingual staff:	0	1
German language:	13	10
Other language:	0	0
Number of Interviews with staff in direct contact with study patients		
Physicians:	15	15
Midwife:	1	0
Nurses:	4	6
Administrative staff:	7	10
Interpreters:	1	3
Number of other interactions observed between staff and study patients through entire process (front desk at arrival and departure, waiting area, nursing care):	16	16

The interview guide was developed based on literature [17, 18, 19] and expertise of the co-authoring physicians (SCH, WL) with subsequent pilot testing and revision. The final version entailed general questions asked in each interview, and questions resulting from observations of the particular encounter to obtain the view of everyone involved. Each interview covered sections on demographics, cultural and social aspects, language, and communication. While patients, e.g., were asked: Were you able to understand everything in the encounter that was relevant to you? Physicians, e.g., were asked if they had the impression the patient understood everything that they perceived as relevant and how they noticed.

An observational grid was developed (KW, SCH) to pre-structure observation [17, 20, 21, 22] of patients' and staff members' interactions. It included general conditions (e.g., attending persons), communication and interaction (e.g., verbal, non-verbal), and potential cultural components (e.g., discomfort due to gender discordance). The observations were recorded in field notes.

Content analysis according to Mayring [23, 24, 25] was conducted (KW) using coding software (MAXQDA). After several cycles of analysis (inductive formation of categories by paraphrasing, generalization, and reduction), a category set entitled "insecure language" was formed with coded text sequences from 40 interviews. Codes within this category set were further analyzed (repeated review of interviews and category building). Open questions were discussed with the senior investigator (SCH). Patients' and health care providers' perspectives were compared and codes collated where appropriate (triangulation⁴). Pseudonyms were used for cited actors and identifying participant details were omitted. For reporting, the COREQ guidelines were used.

The entire process was continuously accompanied by the co-authors' insights and reviews, integrating their experience in communication, interpretation, and cultural competence. It was complemented by discussions with panels among medical anthropologists and clinical ethicists.

Results

Three themes relevant to patients and physicians were identified: "Assessment of the language situation," "use of interpreters," and "dealing with conversational limits."

1. Assessment of the language situation

1.1 Variations in understanding and communication style

Physicians' approaches to assessing their patients' LP and comprehension included patients' facial expression and body language, adequacy of their responses, presumptions about patients' "intellectual capacity," and their individual demeanor. When physicians assessed patients' limited German proficiency (LGP), the relevant question was not whether patients understood, but rather how much. Physicians can judge a patient's conversational understanding as inconsistent over the course of a consultation and be uncertain whether information came across or not. One physician described his difficulties assessing a patient's capacity to understand as follows:

"Often, it isn't easy [...]. Partly, you sense that he understands quite a lot and that he is also able to answer [...], but then there are situations where you get the impression that he understood nothing at all."

Corresponding to physicians' difficulties assessing patients' level of comprehension, patients themselves reported how their capacity to understand clinical conversations depends on the difficulty level of the content, the speaking rate, or familiarity with the provider.

For example, Mrs. Arslan's ability to understand depends on her capacity to cope with her "communicational needs." To understand better, she interrupted the physician repeatedly to summarize or query contents she considered relevant and "checked back." She explained:

"[...] I don't understand much. Maybe [if he] just talks, I don't understand everything. But [if] I ask by myself and he answers me, I do understand well."

While helpful to Mrs. Arslan, Dr. Berg experienced her "strategy" as problematic. During the encounter, he interrupted her repeatedly and directed the conversation back towards his agenda because he wanted to make sure she understood. He guessed her conversational behavior was due to her impatience.

Physicians and patients applied and developed own techniques to address language barriers and found ways to "get by" with insufficient communication and limitations to understanding each other by making several minute decisions.

1.2 'Non-linguistic' factors

Physicians' assessment of patients' LP was not based solely on patients' capacity to express themselves. Additional "non-linguistic" factors were important. When patients appeared to be smart or self-confident, physicians frequently associated these features with a higher ability to

understand. For example, Dr. Berg supposed that the patient was smart and able to understand his instructions on medical treatment despite LGP. He explained:

“[...] she isn’t stupid; it’s just the language barrier that hinders her.”

On the contrary, Dr. Mueller was unsure whether Mr. Begolli’s non-adherence was due to LGP or limited intellectual capacity:

“I (...) just don’t know whether it is a language problem or a problem of intelligence”.

Additionally, he suspected his patient had culturally driven convictions about the appropriate therapeutic approach. From the patient’s perspective, the difficulties were not rooted in the language barrier alone. In the interview, Mr. Begolli mentioned hearing loss, which he had not disclosed to the physician. This example shows how cultural and linguistic factors are not necessarily central but might hinder a more practical understanding.

Beyond that, patients’ self-confidence and resolute demeanor nurtured the impression that there was no language barrier. For example, Mrs. Pepshi firmly requested an iron infusion. Dr. Schmid perceived this as an indicator of her good linguistic skills:

“She was really self-confident, that’s how I also knew that there was no language barrier.”

Patients’ demeanor can influence how physicians rate their patients’ comprehension. However, physicians’ interpretation of a patient’s behavior can be misleading, as in Mr. Begolli’s case, who suffered from hearing loss. Again, minute decisions were made within the encounter with little distinction between patients’ LP, education, health literacy, and cognitive ability.

2. Use of interpreters

2.1 Quality of interpretation and interpreter's reliability

Preference of direct communication, dissatisfaction with professional interpreters' behavior towards patients, and the interplay and possible dynamics between a patient, interpreter, and provider were topics for physicians. Despite positive appraisals of interpreter services, for most physicians—regardless of professional or non-professional interpreters—the quality of interpretation was an issue. Physicians' concerns⁵ ranged from inaccurate interpretation, incomplete information to suspecting that the interpreter does not endorse their communicative agenda, as illustrated by the encounter between Dr. Wieden, Mrs. Abakay, and her husband. When Dr. Wieden spoke about sexual intercourse, she felt deeply uncertain whether the husband interpreted properly to the patient, his wife:

"It was difficult for me to reconstruct whether he really interpreted it to his wife in the way I wanted him to."

Another obstacle was the husband's own limited LP. When it came to medical terms, Dr. Wieden used additional means:

"Fortunately, we have water bottles in the consultation room. So you can explain these [terms] 'watery' or 'mucous'."

Asked what she does when verbal communication is limited, she replied:

"Puh, if it is not possible at all to communicate with gestures or by a mix of English, French, Italian and German, at that point I would, depending on what is the matter, make an appointment with an interpreter as soon as possible."

While an on-site interpreter is called for breaking bad news or when a patient consults the clinic for the first time, telephone interpreting is perceived valuable in case of clinical urgency (e.g., patient shows up in the emergency room with strong vaginal bleeding). In other words, the call for ensuring quality of communication by consulting available interpreting services is a decision determined by medical necessities. In less urgent situations, providers can rely on family members, multilingual hospital staff, own limited second language skills, or communication with gestures.

2.2 Hesitation

Both physicians and patients hesitated when making the decision for or against an interpreter. While physicians tended to doubt that an interpreter would be helpful, patients sometimes wished to manage the conversation themselves. Some patients feared that by asking for an interpreter, they would have to cover the costs or their request would be associated with negative connotations.

Others were not informed about the availability of interpreter services at all.

Time constraints and concerns about disrupting their schedules can limit physicians' use of interpreting services, although they simultaneously acknowledge the benefit of these services and their potential underuse. Dr. Mueller expressed:

"I never used telephone interpreting, but it is certainly a useful innovation although it takes an enormous amount of time. But yes, the interpreting service works out to some degree. One should probably use it much more."

Dr. Mueller further reported that Mr. Begolli was “probably a model example” of a patient who might need an interpreter and that he “probably really should involve” one. When asked why he had not, he confessed:

“I don’t know.”

After the consultation, Mr. Begolli revealed that he would have appreciated an interpreter, but felt uncomfortable with the high cost of the service. Despite knowing that the hospital covers the costs, he feared difficulties with his health insurance because of it. In contrast, another female patient who admitted conversational limitations rejected consulting an interpreter:

“I will come also next time without interpreter. I want to manage it on my own.”

When asked how far she understood the conversation with the physician, she replied:

“I much understood, usual I understood not something missing. I understood. Only for speak I have little problems.”

Her wish to manage on her own is contrasted by her way of speaking, revealed in her answer when translated verbatim with grammatical errors and syntax.

Various decisions need to be made when dealing with a patient’s LGP by providers and patients. Although the language barrier can limit effective communication and influence patients’ capacity to understand physicians’ instructions and information, the decision to call for an interpreter is not necessarily made. Above, the physician concluded that an interpreter should have been involved only while reflecting retrospectively. Patients can consider it empowering to do it by

themselves rather than with interpreters. Altogether, these decisions are fraught with uncertainties and hesitation.

3. Dealing with conversational limits

Being stretched to one's limits to find common ground for mutual understanding was an issue for patients and physicians, which could sometimes result in feelings like "giving up." For physicians, limitations became obvious, when repeated explaining and checking if a patient understood remained unsuccessful and resulted in accepting a patient's lack of comprehension. As a consequence, "not having learned everything" (from a patient's perspective) or "not having been able to communicate everything of importance" (as a provider) were common experiences. One physician explained:

"Some issues certainly remained open. You always try to ask and get to the point, but I don't succeed every time. And then, you somehow give up and move on to the next point."

Patients too accepted these limitations as a given "reality" and faced limits in their attempts to make themselves understood. Yet, for patients, this had a broader meaning including feelings of "being taken seriously" and "being understood." For example, one patient felt the strong need to ask remaining questions about her condition. But the physician cut her off. She wasn't surprised that *"he wouldn't listen"* to her and added resignedly:

"Many physicians do that"

The acceptance of conversational limits—by physicians and patients—stands in contrast to the availability of interpreters. These conversational limits bear the risk of having a consultation and

medical treatment of uncertain quality and presumably lower satisfaction for patients and providers. The uncertainty of this seemingly mundane decision to accept conversational limitations, instead of calling for an interpreter's assistance, is not immediately apparent in everyday practice.

Discussion

Our results reveal a troubling and heterogeneous range of factors shaping decision-making for or against an interpreter's assistance by providers and patients alike. While patients often meet their need for interpretation by bringing someone along to the consultation, they rarely request professional medical interpreters. Providers categorize their patient conversations into ones of high or low medical significance. Physicians tend to use professional interpreters for "high-stakes" conversations, and to "get by" through "low-stakes" topics by resorting to bilingual family members or staff, their own second languages—even if incomplete—or by simply relying on gestures and mimicry.

"Getting by" [1, 3, 4] describes a practice, which is rarely subject to closer examination. While the availability of language services is a necessary precondition for safe and effective communication across languages, physicians occupy a key position to initiate the process of medical interpreting. [5] The seemingly simple decision to call for one or not, particularly when interpreters are available, is very complex and shaped by a range of small, frequently inconspicuous decisions in the "real world" of clinical practice. These decisions are often not part of an "actual process of clinical judgment," [12] and neither subject to critical scrutiny, nor of verbalized considerations or negotiations among the actors within an encounter. When language

barriers exist, one crucial step often seems to be skipped—assessing a patient’s LP. Awareness about the decision-making potential of this very moment and its exploration hardly exists. Instead, research focuses on health care providers’ underuse of professional interpreters and risks though language barriers, [5, 28, 29] the positive outcome when professional interpreters are used, [30, 31, 32] or refers to clinicians’ second-language skills. [30]

Physicians respond with little uncertainty when patients’ LP is either high or absent. Their response is much more ambiguous when patients’ LP is somewhere in between. Guidance on how to assess a patient’s LP for the purposes of a medical encounter is rare [33] aside from awareness for possible varieties in language proficiency and fluctuations in a conversation. [34] While a patient’s limited LP can be sufficient for routine social demands and limited medical requirements⁶, proficiency is insufficient when the course of treatment, for example, reveals a poor medical outcome due to limited communication. Within a single consultation, the degree of problems in a conversation can vary due to fluctuations in difficulty level of content and uncertainties in comprehension by patients and providers. The mosaic-like character of these uncertainties is illustrated by multiple suboptimal circumstances, seemingly unspectacular when each is taken by itself. This reveals the risk of overlooking the significance of single routine actions, their potential importance for the course of a consultation, and the risk of probable subtle but adverse medical outcomes and suboptimal care.

Guidance is rare on how to balance this all to make an appropriate decision, for or against an interpreter’s assistance. This leaves physicians alone with uncertainties and places the responsibility of a decision solely on the individual physician. [35] The conceptual framework of Schenker and colleagues [36] is a valuable exception. It guides “physicians thinking through

difficult choices about language services by four factors: ‘the clinical situation, degree of language gap, available resources, and patient preference.’ But decision-making can be driven by factors more elusive than the objectifiable ones (e.g., available language services), for example, an environment which places higher value “on efficient completion of defined clinical tasks than on ensuring either effective communication or excellent care” [37] or an individual provider’s level of engagement and moral commitment to ensure barrier-free communication.

According to Komesaroff, “ethics is what happens in every interaction between every doctor and every patient.” [12] A “doctor is involved in a constant stream of choices of an ethical kind, which are made at the local level of his or her interaction with the patient [...]. The accumulation of these ‘micro-ethical’ decisions [...] contributes importantly to the final qualitative and quantitative outcome of any particular medical encounter.” [12] Presented results underline the National Advisory Commission on Biomedical Ethics (NEK) request for sensitizing providers to the challenges of cross-cultural communication and calls for teaching clinicians when and how to work with interpreters. [38]

Beyond that, the micro-decisions on the patient-provider level are closely intertwined with institutional conditions like facilitating language services. Within Switzerland, the institution under consideration is one of the advanced environments due to its long-standing availability of interpreter services, guidelines for choosing interpreters (e.g., on-site, bilingual staff), training courses, and crucially, readiness to cover the expenditures for medical interpreting. Nevertheless, huge intra-hospital variations still exist similar to the University Hospital Geneva. [39] These variations range from organizational domains with high use of professional interpreters to domains with reluctant use, promoting bilingual staff instead. Ambiguities and

uncertainties resulting in “getting by” are not only common on a patient-provider level but also on an institutional and even national level. Therefore, the micro-level reflects what takes places on the macro-level.

In Switzerland, the need to address the language barrier is widely acknowledged and the interpreting industry fast-growing. While in the USA, Medicaid has indicated that language services are eligible for federal matching funds [11] in Switzerland, no reimbursement is provided and a uniform solution for cost coverage (e.g., reimbursement by insurance companies) is not settled yet.

Therefore, the financial burden to ensure barrier-free communication in health care rests on hospital decision-makers, or in private practices on the providers themselves, stressing their commitment. The commitments to human rights, to high quality care for all, and good communication are increasingly exposed to economic pressure. With all due respect to the moral imperative “it will be the financial equation that drives real change.” [35]

Research is needed on how LP can be assessed during hospital processing and to better understand physicians’ practice of “getting by” and the factors shaping their decision for—or against—an interpreter’s assistance. Physicians’ decision-making is a key element within the process of medical interpreting and demands more attention. The micro-ethics approach represents a vital concept for promoting awareness on the significance of “getting by” in the daily clinical practice of navigating language barriers. The concrete consequences of these decisions need to be examined in terms of their impact on the individual patient’s course of treatment and medical outcome. Patients have to be acknowledged as decision-makers in the

interpreted encounter, and their attitudes, needs, and factors driving their decisions (e.g., rejection of professional interpreter use) need to be explored. The development and testing of a conceptual framework close to practice is crucial for guiding physicians' decision-making on the use of interpreting services to ensure language equity and high quality care for all patients. However, these steps can only be successfully implemented with the support of institutional and political stakeholders in order to "get away" from "getting by."

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Compliance with Ethical Standards

The Ethics Committee of Northwestern and Central Switzerland (EKNZ) approved the study.

Conflict of Interest

The authors declare that they do not have a conflict of interest.

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- 1 www.nek-cne.ch
- 2 A patient's Turkish nationality mattered for recruitment. Within the study, it was not distinguished between belonging to a minority population in Turkey (e.g., Kurds) or being Turkish.
- 3 Albanian minority populations live in Kosovo, Macedonia, Montenegro, Serbia, and Greece.
- 4 See Würth and Schuster 2017 [26]
- 5 See Sleptsova et al. 2017 [27]
- 6 https://careers.state.gov/gateway/lang_prof_def.html

Article 3

Kristina Würth, Wolf Langewitz, Stella Reiter-Theil, Sylvie Schuster: **Their view: difficulties and challenges of patients and physicians in cross-cultural encounters and a medical ethics perspective.** BMC Medical Ethics (2018) 19:70.

Abstract

Background:

In today's super-diverse societies, communication and interaction in clinical encounters are increasingly shaped by linguistic, cultural, social and ethnic complexities. It is crucial to better understand the difficulties patients with migration background and healthcare professionals experience in their shared clinical encounters and to explore ethical aspects involved.

Methods:

We accompanied 32 migrant patients (16 of Albanian and Turkish origin each) during their medical encounters at two outpatient clinics using an ethnographic approach (participant observation and semi-structured interviews with patients and healthcare professionals). Overall, data of 34 interviews with patients and physicians on how they perceived their encounter and which difficulties they experienced are presented. We contrasted the perspectives on the difficult aspects and explore ethical questions surrounding the involved issues.

Results:

Patients and physicians describe similar problem areas, but they have diverging perspectives on them. Two main themes were identified by both patients and physicians: >patients' behaviour in relation to doctors' advice< and >relationship issues<.

Conclusions:

A deeper understanding of the difficulties and challenges that can arise in cross-cultural settings could be provided by bringing together healthcare professionals' and patients' perspectives on how a cross- cultural clinical encounter is perceived. Ethical aspects surrounding some of the difficulties could be highlighted and should get more attention in clinical practice and research.

Introduction

Migrant health is on the agenda - in Switzerland and elsewhere [1]. The foreign population's increase and its diversification [2] is reflected in Swiss healthcare settings, such as at the University Hospital Basel (USB) where 'non-Swiss' patients made up 35.6 % of all outpatients [3] in 2011. Against the societal background of super-diversity [4, 5] communication and interaction in clinical encounters are increasingly shaped by linguistic, cultural, social and ethnic complexities.

Research on migrant health generally deals with differences between groups such as diverse migrant populations⁴ and respective local populations, for example in quality of care, access to

⁴ The term population with a migration background as defined by the Federal Statistical Office (FSO) 'includes all foreign nationals, naturalised Swiss citizens, except for those born in Switzerland and whose parents were both born in Switzerland, as well as Swiss citizens at birth whose parents were both born abroad'.

care or on health outcomes [6, 7, 1, 8, 9]. Yet, group attributions also hold difficulties and ambiguity as both, migrants, as well as respective local populations, are anything but homogenous social groups. However, literature shows that having a migration background is going along with risks to experience disadvantages regarding health and healthcare provision [6, 10], especially for migrants with a lower socioeconomic status [11].

Diverse aspects are mentioned in the literature as contributing to inequalities in health and healthcare between migrant- and local populations. Besides language barriers [12-14] the impact of 'culture' on cross-cultural communication and interaction has been shown [15-17]. Yet, vague and static cultural concepts, which "reduce individual behaviour to broad stereotypical formulas, or at least encourage such stereotyping," [18] are still often to be observed in the medical context [18, 19].

At group level, ethical questions arise on issues such as the provision of equal opportunities in healthcare for all patients - a society's duty to counterbalance inequalities which lead to health-disparities of diverse social groups [20]. Respective interventions promoted by governmental institutions (e.g. „National Strategy on Migration and Health“[21-23]), thus, aim at eliminating group-specific inequalities.

This study approaches the topic of migrant health in a different way: we were interested in the dimension of the individual and its ethical aspects: beyond the belonging to a specific societal group this dimension results from the immediate interaction with another unknown person. Research investigating clinical encounters between healthcare professionals and patients and

comparing the perspectives on common communication and interaction has been done earlier [24] mostly focussing on different clinical areas or on diagnosis-related patient groups [25, 26]. Using an ethnographic approach, we investigated concrete experiences of patients of Turkish and Albanian origin and physicians they consulted with. The first author, a medical anthropologist, passively participated in their clinical encounters, observed communication and interaction (participant observation) and later interviewed patients and physicians about their perceptions of the encounter and the difficulties they had experienced. We provide views on the two most prominent categories of difficulties identified in the study: >patients' behaviour in relation to doctors' advice< and >relationship issues< and explore the surrounding ethical questions.

Methods

This paper about difficulties and challenges is part of a larger ethnographic study ("Hospital Ethnography at the University Hospital Basel") on how patients and healthcare providers perceive their shared clinical encounters. We investigated issues influencing communication and interaction and tried to identify ethical aspects.

Based on hospital figures on outpatients and interpreter assignments, 16 patients of Turkish- and 16 of Albanian origin were recruited at the Medical Outpatient Clinic (MOC) and at Women's Outpatient Clinic (WOC) of the USB. 94 semi-structured interviews (patients and staff members) were conducted by the first author (KW) between August 2012 and January 2015. Several cycles of analysis on aspects relevant to the overall research question of the larger study (inductive formation of categories) resulted in the category set >difficulties and challenges<. The 34 semi-structured interviews in this category set have been used for this article (see table 1). Interviews

52

lasted up to 90 minutes, were tape-recorded and transcribed verbatim. The study was ethnographic in approach corresponding to the embedded research approach in medical ethics [27] and was approved by the Research Ethics Committee of North-Western and Central Switzerland (EKNZ).

Selection for recruitment was based on the list of patients scheduled for the next day if patients' names suggested an Albanian or Turkish origin. At recruitment KW approached selected patients in the waiting area of the clinic, introduced herself as a PhD student conducting a study about cross-cultural communication. If patients had a follow-up appointment with the outpatient department (OPD), they were asked whether they would be willing to participate in the study. Patients with a Turkish/ Albanian sounding name but of non-Albanian/ non-Turkish origin (e.g. through marriage) and patients under 18 were excluded from the study. Written informed consent was obtained from all interview partners in German, Turkish or Albanian.

On the index day, KW met the patients in the entrance area of the respective clinic and accompanied them during all encounters they had with hospital staff (front desk staff, nurses, physicians and interpreters as required). Each involved staff member was also asked whether they were willing to be interviewed afterwards. (These data will be presented in another paper, here we report only on doctors' and patients' perspectives.) In general, patients' interviews were conducted directly after consultation, staff members' interviews were conducted as soon as possible after the interaction, usually the same week.

An observational grid served as a research instrument and for pre-structuring observations [28, 15, 29, 30]. It included aspects of verbal (e.g. conversation content, contribution to conversation), and non-verbal communication (e.g. mimicry, bearing) as well as interaction

sequences according to social- (e.g. educational background) or culture-associated factors (e.g. regarding physical contact, gender). Relevant observations were noted in the interview guide. Besides participant observation during clinical encounters, KW performed general observations (e.g. front desk procedures) or held informal talks with staff and patients during long-time presence at both OPDs. After data collection, all observations were recorded in a field diary.

Table 1 List of patients and doctors who were interviewed

Interview	Clinic	Role	Stated education	Years in CH	Subject of appointment
1	WC	Patient	Secondary school	11-20	Review Cysts
2	WC	Patient	Secondary school	0-10	Review Pregnancy
3	WC	Patient	N/A	21-30	Review Coil
4	WC	Patient	Secondary school	0-10	Annual routine review
5	WC	Patient	High school	21-30	Review Menopause
6	WC	Patient	Lower secondary school	11-20	Review Pregnancy
7	MC	Patient	N/A	21-30	Review Diabetes, hypertonia
8	MC	Patient	High school	21-30	Review Rheumatism
9	MC	Patient	N/A	11-20	Review Pain
10	MC	Patient	Lower secondary school	11-20	Review Rheumatism
11	MC	Patient	N/A	11-20	Review Hypertonia
12	MC	Patient	Secondary school	21-30	Review Hypertonia
13	MC	Patient	High school	N/A	Discussion lab results
14	MC	Patient	N/A	21-30	Review Hypertonia
15	WC	HCP	N/A	N/A	N/A
16	WC	HCP	N/A	N/A	N/A
17	WC	HCP	N/A	N/A	N/A
18	WC	HCP	N/A	N/A	N/A
19	WC	HCP	N/A	N/A	N/A
20	WC	HCP	N/A	N/A	N/A
21	WC	HCP	N/A	N/A	N/A
22	WC	HCP	N/A	N/A	N/A
23	WC	HCP	N/A	N/A	N/A
24	MC	HCP	N/A	N/A	N/A
25	MC	HCP	N/A	N/A	N/A
26*	MC	HCP	N/A	N/A	N/A
27	MC	HCP	N/A	N/A	N/A
28	MC	HCP	N/A	N/A	N/A

29	MC	HCP	N/A	N/A	N/A
30	MC	HCP	N/A	N/A	N/A
31*	MC	HCP	N/A	N/A	N/A
32	MC	HCP	N/A	N/A	N/A
33	MC	HCP	N/A	N/A	N/A
34	MC	HCP	N/A	N/A	N/A
*same HCP					

The semi-structured interviews combined a set of pre-defined questions developed from the literature study and questions that were triggered by the clinical experience of two practicing physicians in the research team (SCH & WL) in cross-cultural encounters. Interview questions were supplemented with observations KW had made during the clinical encounter under examination [15, 31]. Each interview covered sections on demographics, cultural and social aspects, language and communication. The interview guide was pilot tested during five interviews, discussed among the authors and revised accordingly. In the interview section that specifically addressed the index encounter, patients and doctors were first asked whether they themselves had experienced difficulties or challenges. Then, in line with the observational grid, observations made during the clinical encounter, were brought up. Language during interviews was based on the same conditions as during medical consultations: Most interviews were conducted in German, if patients had used an interpreter (professional or non-professional) during medical consultations, the same interpreter was also involved for the interviews.

Data of the semi-structured interviews were evaluated content-analytically according to Mayring [32-34] using the qualitative analysis software MAXQDA for coding and analysis. Observational data were primarily used during the interviews; all field notes (e.g. on observations during clinical encounters, drawings on the setting, general observations about the setting) were filed.

Interviews were analysed simultaneously; from the beginning, commonalities and differences in patients' and physicians' perspectives were acknowledged. Interviews with coded text sequences in the category set >difficulties and challenges< were analysed further for respective content: significant interview sections were marked and discussed among the authors. Next, text sections were coded, reduced and verified in several cycles. Codes and sub-codes were developed inductively. Coded sections of patients' and physicians' interviews were compared, and codes were collated where appropriate (triangulation). Presented interview citations are labelled with the interview number according to table 1.

Results

The larger study including hospital staff, patients, nurses, and doctors, revealed diverse topics some of which were specific for different groups and others overlapping between them. For example, specifically in professional groups of administrative- and nursery staff, a major category entitled >professional stance< was formulated including personal attitudes and mind-sets towards migrant patients and migrants in general. For the purpose of this paper, we tried to identify topics that were common to patients and, at least, one of the other healthcare professional groups. There, a major issue common to patients and physicians concerned perceived difficulties. The respective category >difficulties< included two main problem areas: >patients' behaviour in relation to doctors' advice< and >relationship issues<.

Patients' behaviour in relation to doctors' advice

Physicians reported of patients who took medication in wrong doses or at the wrong time, patients' insufficient or lacking record of medical values (e.g. blood sugar values to adjust insulin

treatment, or blood pressure values to control hypertonia) or of patients forgetting to bring these records to the consultation. Patients referred to these as well and mentioned difficulties in following the doctors' suggestions, especially concerning medication, self-monitoring and adhering to follow-up appointments.

Both physicians and patients also offered some explanations why these behaviours occurred. These explanatory concepts will be described in detail in the following section.

Views of physicians

>Deficiencies<

>Missing understanding of medical concepts<, >lack of basic medical knowledge< and >intellectual barriers<

A physician talking about his frustration about a patient with gestational diabetes, who again did not bring the blood-sugar diary to the consultation, explained:

"I think she hasn't the basic [medical] overview [...] very often, women do not see that high blood pressure has to do with the child and that blood sugar is connected to pregnancy. [...]" (I 19)

Another physician presuming similar reasons for her patient not following therapeutic instructions for losing weight additionally stated:

"[...] maybe she is also intellectually not capable to understand how these medical facts are linked [...]." (I 21)

and further guessed:

"[...] not only laziness or habit hinders her, [...] also she is not aware that she really could reduce her climacteric symptoms by losing weight." (I 21)

Dealing with non-fulfilment of medical recommendations was also linked to considerations about >responsibility<. For example, one physician concluded after a patient had not followed medical advice:

“I am quite pragmatic here. The patient is 18 years old, he is responsible and obviously he isn’t neuro-cognitively disabled. [...] This is no longer topic for me then.” (I 28)

>Ignoring medical reality<

>Fixation on own ideas<, >not seeing the seriousness< and <indifference towards one’s own health<

A physician speaking about a patient with hypertension not measuring blood pressure at home and recording them in a diary assumed him to be:

“[...] one of those patients with migration background [...] having quite different ideas about how to look after health or what to do for it.” (I 27)

Also, he admitted wondering to what extent this patient wished to be informed at all regarding improving his condition, saying:

“Some [...] informed patients, they also query by themselves [...] and then you sense [...] when you explain [...] it falls on fruitful ground, they implement it. And with him I had the impression, even if I would engage in explaining once again, he cannot or doesn’t want to implement it.” (I 27)

Other related explanations in this context are summarized under the categories ‘disinterest’, ‘having other priorities than health’ or ‘little suffering’.

Views of patients

>Being afraid of negative results<

Regarding self-monitoring issues, some patients with rather poor general living conditions (difficulties in the private field, additional health issues) revealed to be afraid of seeing their own negative results (e.g. high blood pressure values) because this would lead to even more distress (e.g. anxious thoughts). One patient explained his difficulties in taking the values at home:

“You know, if you know about the risks [of high blood pressure] then you get upset. If you don’t know about the dangers of these diseases, then you can comfortably note [the values]. Yeah, you can measure five times and note it ten times. But I KNOW the dangers of hypertension, diabetes and other diseases.” (I 7)

Another patient suffered from similar fears. When he was asked to measure blood pressure during consultation, he measured a second and third time on his own initiative. Afterwards he explained his reasoning behind this behaviour:

“I hate this. [...] When I see the blood pressure measuring device I always get afraid and then the value is automatically too high.” (I 12)

and further revealed why he feared seeing high values:

“I want to see that it [blood pressure level] is ok. Then I can go [home]. I don’t want to go home with one hundred fifty, one hundred sixty. [Because] then, I always wonder ‘hmmm? Why is this so?’, and again and again...” (P15)

>Social distress<

Distressing factors such as workplace-related issues or family issues were mentioned as common reason for not following medical advice. When asked for the reasons why he didn’t self-monitor blood pressure at home, one patient, working in two jobs, revealed:

“When I [get up] in the morning, I am tired. When I come [home] in the evening, I am also tired, you know. [There is] Not much time.” (I 11)

But later he added hoping for an improvement of his health situation after quitting the second job where he experienced particular distress because of his writing difficulties:

“Now we have a fair [...] I have a [...] boss who is a little strict. He wants us all to take written notes. This provokes a little bit stress.” (I 11)

Another patient revealed a difficult family situation and financial problems provoking distress and making it difficult to follow complex treatment instructions.

Relationship issues

Both patients and physicians described experiencing difficulties at the level of their relationship.

Physicians mentioned difficulties in perceiving the patient as a tangible person (e.g. “I cannot not FEEL what’s s/he like”), with demands of patients (e.g. when insisting on prescriptions), patients’ pain expression (e.g. difficulties in attributing expressed pain to physical symptoms) and with the role of male family members (e.g. husbands speaking for their wives). Patients felt not being taken seriously (e.g. when they perceived a physician’s response to their complaints as insufficient) or fobbed (e.g. when prescriptions in pain medication didn’t meet their expectations) and registered a lack of careful attention from physicians (e.g. when physicians didn’t know certain details from a patient’s record). Also, some patients reported a sense of discrimination that they attributed to their origin, their nationality, or their language [problems].

Views of physicians

Difficulties in perceiving the other as tangible person, reaching common ground

One physician tries to explain what in his view renders relationship-building with migrant patients more difficult compared to Swiss patients:

“[...] I called her [a Swiss patient] because I had to know something. I just got the feeling I actually capture how she is, or rather is. And I can react on this. Or I also sense how I am perceived, if she understands me or if

she takes my statements completely wrong, [...] it is a bit about what's in between the lines. This [feeling] I frequently experience as less present with migrant patients.” (I 29)

Another physician explains his frustration with the distance he perceived during the encounter with a middle aged Albanian woman with joint pain:

“[...] it was not the whole language issue that bothered me most, but rather how she is in her behaviour. I don't know, she was very reserved; you really had difficulties in knowing what she thinks [...]. There was a lot of distance.” (32)

Later, he specified what he had been missing:

“[...] how you are feeling, comfortable, uncomfortable why and so on. [...] Everything that's in your head but that you probably won't say.” (I 32)

Demanding patients, exaggeration of pain expression

Some physicians viewed patients' behaviour as overly demanding with an imbalance between high claims towards physicians and low willingness to contribute themselves to improve their health. One physician specified:

“[the patient] he comes with quite concrete claims and relatively low own activity. [...] He needs a medical certificate, he needs - in his first consultation - he needs prescription for physiotherapy [...] then he unexpectedly showed up in-between because he just got a little cold needing a recipe [...] He always comes with a whole range of prescriptions [needed] but seldom [says] [...] ‘Would you have any suggestions of what I (!) can do?’” (I 29)

Some patients' ways of expressing pain created challenges for many physicians particularly because they felt that patients' >exaggerated the expression of their own suffering<; they found it extremely difficult to >get a grip on the pain< described, feeling uneasy to address it. For example, one physician assumed his patient had heavily overstated his rheumatic pain:

“Based on our results I wasn’t able to reconstruct [his pain] from having difficulties walking up to [using] the wheelchair. And that is why I had the impression it was also a bit a primary gain for him.” (31)

Another physician having similar difficulties in finding “objective” problems (e.g. “an inflammation”) in understanding his patient’s vociferous reactions on diverse moves during physical examination:

“The problem is that it [the moves during physical examination] didn’t fit with her wailings. [...] It wasn’t really connected [to the medical results].” (I 32)

Role of family members

Physicians often perceived difficulties in communicating openly or directly with their patients. This held particularly true for some female patients’ in whom the presence of their husband was perceived as blocking an open exchange with the patient. One female physician describes her feelings of frustration:

“There are some women, I think [...] if they were alone, they could speak more than just one word. And if the husbands are with them they don’t do so. [...] For example, if I ask, ‘does your wife have this and that’ he is not asking her but just says ‘no’.” (I 19)

Views of patients

>Not being taken seriously<, >being fobbed< and >lacking attention<

The impression of not being taken seriously came up e.g. when a concern was not dealt with the way a patient had expected. One pregnant woman said:

“I have always told [that I have headache]. But [she] always asks if I drink enough. [...] As soon as I say I have headache the question comes up if I drink enough. I find this a little strange [...] because I drink enough and she always says to me ‘[you have headache] because you must drink more.’” (I 2)

Another patient alluded to a similar sense of neglect when she said:

“they actually say I have nothing, they don’t find anything. But I also don’t know where the pain comes from. This is very difficult for me because I have pain, my belly is swollen and they don’t know where it comes from. [...] A colleague of my mother came three times here, she complained about pain and they sent her home saying she had nothing at all. Finally, it came out that she had breast cancer.” (I 1)

Some patients reported of experiences making them feel fobbed:

“I had so much pain. [...] If you go to the doctor because you need help and you say, ‘I have pain’ he gives you a pill without knowing what exactly you have. For example, I have problems with my joints and he gives me medication for flu.” (I 10)

The sense of missing attention was also manifest in quotations like >s/he was not interested in me< or >s/he was not prepared for the encounter<. One patient who felt her physician had missed to catch up a specific point during consultation complained that she had not read the medical record properly even though she had had the time for doing so. She told the interviewer:

“Although she has had the time [to read the medical record [written in German]], she waited [for the interpreter]. During this time, she should have read [the medical record] more thoroughly.” (I 3)

A sense of discrimination

Feelings of discrimination or being treated harshly were expressed and sometimes attributed to the patients’ origin, nationality or language. One patient spoke about her experiences with unfriendliness of staff members. When she was explicitly asked whether she thought that this was connected to her limited language skills, she admitted hesitantly:

“Yes. [...] Because you sense how one talks to you [...]” (I 2)

Another patient who felt rejected without having received medical help repeatedly was very clear on that matter:

“[they might think] ‘anyway he won’t complain’, maybe because I am an Albanian. [...] I really do think that way! You know, [they just think] ‘he won’t complain.’” (I 10)

Discussion

This study presents difficulties that migrant patients and physicians experienced in their cross-cultural clinical encounters and explores which ethical issues are connected with them.

The category >problems with patients’ behaviour in relation to doctors’ advice< included taking medication in wrong doses or at wrong times, insufficient or lacking record of blood sugar or blood pressure values or carrying respective records to the consultation. Physicians usually located reasons for these issues on the patients’ side, referring to shortcomings such as patients’ denial of >medical facts< or >lacking medical knowledge<. Patients reported struggling with such problems such as >being afraid of seeing their own negative results< or problems with regard to >social distress< (e.g. at their workplace). Comparing the patients’ and healthcare providers’ explanations on the reported issues reveals meaning differences. For example, a physician supposes his patient to be >fixated on own ideas< about the disease and therefore not following his medical advice. The same patient assumes that workplace distress is hindering him from following therapeutic instructions.

Using the process of change developed by Prochaska and Di Clemente [35-37] helps to acknowledge that doctors and patients seem to be aware of the problem, even to agree on the significance of finding common ground and reaching shared decisions about treatment and behaviour. Thus, the similarity of the description of problem areas is a promising finding in itself, showing that both parties are not indifferent, i.e. in the state of pre-contemplation [35]. However, when doctors and patients realise that they actually did not reach common ground, the strategies they apply do not prove successful. Some of the physicians' explanations on the reasons why patients did not follow their suggestions are reflected in the scientific discourse on social determinants of health: contextual medical knowledge is based on educational background, a vulnerability factor deeply influencing health outcomes [11, 38]. This connection is also consistent with basic socio-demographic information provided on patients presented in this study (table 1). Links between the physicians' perceptions of patients, their origin and socio-economic status have been shown by van Ryn et al. as well as the observation that physicians tend to perceive patients with lower socio-economic status as less intelligent than others [39, 40].

Relationship issues reported by physicians included experiences of distance from- or inability to connect with their patients, demanding behaviour, patients' pain expression and their experiences with the role of male family members. Relationship issues reported by patients included feelings of not being taken seriously or fobbed, lacking attention on behalf of physicians and feelings of discrimination. The comparison of reported problems raises questions on how these issues relate to each other and how they impact a clinical relationship (e.g. physicians' experiences of distance occurring alongside patients' frustrations of not being taken seriously).

An important ethical aspect derives from the question of how shared decision- making can be ensured under such circumstances.

A large body of literature has shown that healthcare professionals and patients often encounter challenges in their interactions due to differences in language, culture or (religious) value systems [41-44]. From a medical ethics perspective, difficulties of migrant populations have particularly been discussed in the light of cultural difference and its implications for a principle-based approach [45], for example when the principle of autonomy collides with the wish to act culturally sensitive due to differences in (understanding of) moral values as shown by Minkhoff [46]. However, the problem of mutual misunderstandings is interesting insofar as it seems to indicate a fundamental incongruence at a level below cognitive differences or differences in values. Drawing from their experience with Swiss patients, doctors realise that resonance is often difficult to reach with patients from a migration background. Phenomenological theory offers the term >immediate impression< to describe what is missing here: an effortless and immediate sense of mutual understanding that cannot be derived from single observations like facial expression or prosody. “When we have such an immediate impression, we can almost instantly understand and enact the appropriate behavioural response.” [47]. As far as policy making is concerned, probably raising problem awareness is necessary first on both sides by introducing this concept. Immediate impression resembles the idea of “mentalising” [48] being defined as the ability to understand the mind of another person (and of oneself). Interestingly, some hospitals in Switzerland have realised that (even) doctors and nurses from Germany sometimes need a “sensitisation course” for working with Swiss colleagues and patients, as sharing a language is a necessary, but not sufficient condition to reach common ground.

Reducing the disadvantages of patients with migration background by implementing interventions to improve communication in cross-cultural encounters is intrinsically linked with the question of responsibility (for action). At higher level, institutions or policymakers adopt this task establishing health policies to reach that goal. Within the dimension of the individual encounter the question of responsibility is more complex. Usually, changes in behaviour are based on the perception of not just a difficulty but of a *problem*. For such a change in perspective – from simple difficulties to problems requiring action - one point of reference could be what Ahola-Launonen (2015) calls an “evolving idea of social responsibility in bioethics”. Some medical ethics approaches promote an individualistic view on health placing the individual’s responsibility for his/ her own health in the centre – quite similarly to the overall individualistic tradition of medical history. A physician’s comment on his patient not following medical advice mirrors this basic attitude perfectly “*The patient is 18 years old, he is responsible and obviously he isn’t neuro-cognitively disabled. [...] This is no longer topic for me then.*” (I 28). Yet, against the proven background of social factors contributing to health [11, 41], a call for medical ethics to take the social context into account has been made, arguing that “holding individuals solely responsible for their own health is not a fair conclusion, because so many determinants of health are beyond the individual’s control” [49]. We assume that acknowledging this view may contribute to a climate in medicine where the social perspective can become an integral part of what is considered relevant for an individual’s health. On the individual level of encounter, such a shift in assumption helps to reduce the discrepancy which arises when regarding the patient as an “autonomous agent” [49] and on the other hand being confronted with his/ her health-related behaviour which is based on social or personal conditions.

But the issue of responsibility also arises in another respect: explanations of some physicians held on why patients did not follow medical advice seem to have something “ultimate” about it (e.g. assuming a patient does not follow treatment instructions because he/ she is fixated on own ideas is suggestive of being the end of efforts to solve this situation and find other ways to overcome barriers to effective treatment) and include questions about responsibility and duty of care towards a patient in need: (when) is it allowed to stop trying? The concept of professionalism which “requires that doctors adhere to certain principled responsibilities” [50] includes the responsibility to reach a shared understanding, in a sense that the patient makes an informed choice. Against the background of lacking resonance and difficulties in finding common ground, ethical shortcomings in the apparent absence of shared decision- making become obvious though.

Limitations

Compared to quality criteria from quantitative research and on the basis of the interpretive paradigm, the study’s objective is not generalisation of results, but providing “a rich, contextualized understanding of some aspect of human experience through the intensive study of particular cases” [51]. The question whether our findings have any bearing beyond the specific setting of the USB, the hospital where the investigation took place, cannot be answered by a simple reply, but has to be put to discussion. Assuming that hospitals differ in their very communication culture, we cannot exclude that a similar investigation in another hospital would find different topics relevant. On the other hand, the most important areas of interest that are reported in this paper reflect those that have been mentioned in the literature. However, we used the strategy of triangulation by including several different data sources (patients and

68

healthcare professionals) and using different data collection methods (interviews and observations) to ensure trustworthiness of our findings.

Conclusion

Our innovative approach used to assess problems that arise with cross-cultural communication in medicine by combining participant observation of clinical encounters with reflection in doctors and patients' accounts of what had occurred in these encounters, proved fruitful as it led to rich data stimulating reflection. This detailed approach points to the importance of concordance for both, patients and physicians, and the importance of clinical relationships. Taking the proven links between migration background and inequalities in health, insights provided are crucial to better understand what the difficulties on the individual level of encounters are and how medical ethics can contribute to a shift in perception, from simple difficulties to *problems* having real consequences. Similar studies should investigate clinical encounters with diverse patients in other settings or hospitals to further validate our results or identify additional issues associated to these.

Declarations

Ethics approval and consent to participate

The study, data in this article emerge from, has been approved by the Central Regional Ethics Committee Ethikkommission Nordwest- und Zentralschweiz (EKNZ), Reference number 344/11). Written informed consent was obtained from all interview partners in German, Turkish or Albanian.

Consent for publication

Not applicable.

Availability of data and material

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

KW carried out the interviews, did the data analysis and drafted the manuscript as part of her PhD project. WL contributed to the interpretation of the data and revised the manuscript. SCH supervised the study, contributed to the analysis and interpretation of the data and revised the manuscript. SRT contributed to the interpretation of the data and revised the manuscript. All authors read and approved the final manuscript.

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Abbreviations

USB: University Hospital Basel; MC: Medical Outpatient Clinic; WC: Women's outpatient clinic;

EKNZ:

Ethikkommission Nordwest- und Zentralschweiz; NCE: Swiss National Advisory Commission on

Biomedical Ethics; HCP: Healthcare professional.

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III. Discussion

This dissertation explores how migrant patients and healthcare providers experience their shared clinical encounters at the University Hospital Basel and presents aspects relevant from a medical ethics perspective.

In the following, the major results of each article are presented (1) and discussed in summary against the background of the current literature (2). Then, strengths and weaknesses of the study are discussed (3). Finally, suggestions for future research are derived from the results (4). The publications, on which this dissertation is based, are referred to in the text by their Roman numerals (I-III).

1. Overview of main findings

(I) "Some of them shut the door with a single word, but she was different" – A migrant patient's culture, a physician's narrative humility and a researcher's bias. (2017)

This 'reflective practice article' (Hatem and Rider 2004) is a narrative about our reflections on a witnessed cross-cultural clinical encounter. In this essay the topics 'culture', 'biases' and 'stance' in a cross-cultural clinical encounter are addressed. The key lessons are:

- 'Cultural issues' do not always have a central position in a cross-cultural clinical encounter and the concept of culture should be used only in a cautious and mindful way to avoid the 'culturalization' of issues rooted in other areas.
- The physician's open stance, expressed for example in the way questions were asked or in the willingness to listen to the patient's story without interrupting and in a non-

judgmental way, helped to establish a reciprocal relationship, which was fundamental to their mutual understanding.

- Interactions between patient and physician are consistent with what is described in the concept of narrative humility. Besides the importance of mutuality, receptivity and transparency in clinical relationships, it also includes a critical view on an overemphasis of the term 'competence' as it is suggestive of someone's story (or culture) being something which can be completely understood or simply mastered.
- From the outsider's perspective of the researcher, it is remarkable to observe how stereotyping just happens regardless of one's profession, knowledge or experience. Becoming aware of own biases through self-reflection is an ongoing task.

(II) "Getting by" in a Swiss Tertiary Hospital: the Inconspicuous Complexity of Decision-making Around Patients' Limited Language Proficiency. (2018)

This article investigates the practice of 'getting by' with patients' limited language skills in cross-cultural clinical encounters and the inconspicuous complexity of decision-making surrounding it.

The main findings are:

- The assessment of a patient's language ability within daily clinical encounters was often lacking, judgements were made without reflection and also shaped by diverse non-linguistic factors (e.g. a patient's body language or appearance).
- Decision-making regarding the involvement of professional interpreter services was driven by a range of non-linguistic factors (e.g. depending on the relevance of the medical topic; patients' wish to manage it on their own).

- Decision-making in favour of or against involving an interpreter often happened without reflection
- The micro-ethics approach promotes awareness on the often not reflected process of decision-making in the context of 'getting by' with patients' limited language skills.

(III) Their view: difficulties and challenges of patients and physicians in cross-cultural encounters and a medical ethics perspective. (2018)

This research article highlights and compares patients' and physicians' perspectives on experienced difficulties and offers a discussion from a medical ethics perspective. The major findings are:

- Two problem areas proved to be relevant: the patient's behaviour in relation to the doctor's advice (e.g. suspected to be caused by lacking medical knowledge; due to social distress) and relationship issues (lacking resonance; not being taken seriously).
- Patients and physicians described the same problem areas suggesting that they were both aware of the same problems, but their respective views on these issues were diverging.
- Different ethical implications were found, for example regarding how shared decision-making can be made in the context of relationship issues (e.g. feelings of discrimination); or regarding the social determination of health and questions of responsibility for one's own health (e.g. low medical knowledge in the context of low educational background).

2. Summary Discussion

The aim of this dissertation study was to investigate how migrant patients and healthcare providers experience their clinical encounters at the USB. We were interested in aspects beyond so-called 'core cultural' issues (Carrillo et al. 1999) influencing communication and interaction. We also explored which of our findings included an ethical dimension or suggested ethical relevance. Topics that have materialized throughout our study, i.e. those that are analysed in articles I-III are discussed in summary below.

2.1 Stance

The topic "stance" - understood as the inner position from which one witnesses another's story (DasGupta 2008) - came up in different ways during this study and was alluded to by both patients and physicians implicitly or explicitly in diverse contexts.

For example, as we could show, perceptions of a successful encounter despite possibly relevant differences (e.g. in language proficiency or in social and/ or cultural background) were linked to a shared experience of an open and receptive stance (I). Accordingly, in cases where openness was perceived to be missing, challenges in communication and interaction were experienced (III). Physicians in our study reported to perceive this more often in consultations with migrant patients than with Swiss patients. They repeatedly described subtle difficulties in perceiving the other as tangible and in reaching a shared understanding. Vice versa, patients reported to perceive hospital staff's attitudes towards them as unfriendly or discriminatory due to the patient's nationality or background (III).

The significance of mutuality and receptiveness in clinical relationships is also described by DasGupta (2008). In her approach on 'narrative humility' she defines a *stance* which is 'other-oriented' towards patients and their illness narrative, and shaped by constant self-awareness regarding own prejudices and expectations. Following Tervalon and Garcia in their concept of cultural humility (Murray-García and Tervalon 2014), DasGupta includes a critical look on the so called competence approaches. What makes a difference between *competence* (e.g. narrative, cultural) and the idea of *humility* is expressed by the term *stance* which directs the focus on our inner attitudes towards someone rather than to our learned technical behaviour. This also includes the awareness of a fundamental aspect characterizing our relationships to others, namely that "we cannot ever claim to comprehend the totality of another's story, which is only ever an approximation for the totality of another's self" (DasGupta 2008). Clinical relationships where the physician puts him-/herself in a position of receptivity, and where "the call of the suffering Other" (DasGupta 2008) is answered, create mutuality which is valued highly beneficial to clinical relationships (Tsevat et al. 2015; DasGupta 2008; Charon and DasGupta 2011). Our results confirm the importance and benefits of this aspect of clinical relationship from several sides, when it is perceived missing (III), when it is experienced as present (I) and both, on behalf of patients (I, III) and physicians (I, III).

2.2 Decision-making in the context of language barriers

Despite increased efforts to overcome language barriers in healthcare, e.g. through the provision of professional interpreter services, language barriers still are a major topic in cross-cultural clinical communication (Divi et al. 2007; Marmot et al. 2012; Flores et al. 2005; Flores 2005; Hudelson and Vilpert 2009). It has been shown recently that, regardless of their availability,

professional interpreter services are often underused in clinical practice. Instead, physicians choose to get by with patients' limited language skills (Diamond et al. 2009). We identified the practice of 'getting-by' (Diamond et al. 2009; Hsieh 2015; Bischoff and Hudelson 2010) to be most prominent when patients' language skills were in the intermediate range of competence (I,II). Physicians used professional interpreters for 'high-stakes' conversations and did 'get by' when seemingly 'low-stakes' topics were to be dealt with.

In these patients we have shown that a decisive step of navigating language barriers often seems to be ignored: the (deliberate) assessment of a patient's language proficiency. Instead, decision-making for or against an interpreter often seemed at best not well reflected and, as we could show, shaped by a range of factors - of which most were difficult to objectify - on behalf of physicians (e.g. a patient's body language, medical significance of the topic of the consultation) and patient (e.g. wish to manage on their own) (II). The indication that the degree of the language barrier plays a role in dealing with it has been addressed earlier (Schenker et al. 2008). Yet, our results illustrate that dealing with such language gaps in daily clinical routine is a process which often is not part of an "actual process of clinical judgement" (Komesaroff 1995) neither subject to critical scrutiny nor of verbalized considerations or negotiations among the stakeholders within the clinical encounter (I,II). Guidance for the necessity to identify language barriers in the clinical setting is rare (Karliner et al. 2008) as is awareness that language proficiency is a continuum with possible nuances and fluctuations within a conversation, for example depending on difficulty level of content (Johnson et al. 2014). Schenker et al. have provided concrete indication for physicians within the decision-making process surrounding patients' limited language proficiency ("the clinical situation, degree of language gap, available

resources, patient preference”) (Schenker et al. 2008). However, we found decision-making to be driven by additional factors which were more elusive than the ones described by Schenker et al. (2008), for example a healthcare professional’s personal attitudes (II) or the experiences of mutuality during the clinical relationship (I).

2.3 Concordance and relationship

Within the observed clinical encounters, certain situations occurred repeatedly with topics perceived as difficult or suboptimal by patients and physicians alike. Beyond the topic of language discussed previously, the (perception of) problems condensed in two areas, namely in concordance (II, III) and relationship (III). The area of concordance was manifest in problems with patient behaviour in relation to a doctor’s advice (e.g. taking medication in wrong doses or at wrong times, insufficient or lacking record of blood sugar or blood pressure values). While both parties did recognize the same issues, the perspectives on reasons differed between patients and physicians, e.g. denial of medical facts (*physicians*) versus workplace-related distress (*patients*). Relationship issues manifested in experiences of distance or inability to connect with patients, their demanding behaviour and patients’ pain expression (*physicians*); also, difficulties with the role that female patients’ male family members played were mentioned (*physicians*) as well as feelings of not being taken seriously or fobbed off, lacking attention on behalf of physicians and feelings of discrimination (*patients*) (III).

The similarity in patients’ and physicians’ descriptions of problem areas (e.g. importance of common ground (I, III)) is a relevant finding in itself. Its significance becomes apparent when using the process of change described by Prochaska and DiClemente (Prochaska 2008; Prochaska and DiClemente 1982). It shows that both patients and physicians are not indifferent, i.e. in the

state of pre-contemplation (Prochaska 2008) but reflect on factors that might contribute to problems in interaction, among them social determinants of health such as (a lack of) employment and education (I, II, III). It corroborates earlier findings, e.g. of Gültekin (2017) in patients (Turkish women felt confronted with social stressors during treatment of type 2 diabetes) (Biyikli Gültekin 2017), or of van Ryn (2000) and Burgess et al (2006) in physicians (links between a physician's perceptions of patients with their origin and socio-economic status) (van Ryn and Burke 2000; Burgess et al. 2006). The importance of mutuality and resonance in a clinical relationship has been emphasized before (2.1) and is supported by corresponding findings: e.g. difficulties with 'connecting' to migrant patients (physicians), feelings of lacking attention (patients) (III). Physicians' problems with lacking resonance point to a subtle everyday aspect of 'our communicative world' which is rarely under investigation in research: the 'immediate impression' understood as an "effortless and immediate sense of mutual understanding that cannot be derived from single observations like facial expression or prosody" (Langewitz 2007). The patients' experiences of difficulties within clinical relationships manifested differently, namely in the perceived discrimination due to their foreign origin and connected issues (e.g. language barriers). (Perceived) discrimination in healthcare has been shown repeatedly (Hudelson et al. 2010; Schmidt et al. 2018) and has even been associated with concordance in migrant patients (Sheppard et al. 2008). This underlines our assumption that concordance and issues relating to a clinical relationship (e.g. physicians' experiences of distance occurring alongside patients' frustrations of not being taken seriously) could be connected.

2.4 Ethical reflections

Throughout our study ethical aspects evolved from inconspicuous daily clinical routine of cross-cultural clinical encounters.

Our findings point to a number of such ‘everyday issues’ in which both patients and physicians are engaged (II, III). This includes, for example, the previously mentioned attitude of ‘getting-by’ with patients’ limited language skills in a linguistic grey area, relationship issues or social aspects (I, II, III). One common aspect of these ‘everyday issues’ was their tendency of not being recognized as being potentially serious (II, III). The realm of ‘the everyday’ constitutes a distinctive part of what social science is interested in and where respective theorization has been done (Highmore 2002). Zizzo et al. finds that “ordinary topics of healthcare and medicine” are rarely examined in medical ethics, compared to more “dramatic ethical issues” of medical practice (Zizzo et al. 2016).

However, there is a missing link between this view and key concepts in medical ethics such as the doctrine of Informed Consent which have made their way from mere ethical recommendations to definite legal requirements and, thus, have entered everyday clinical routine (Veatch 1972). Moreover, following criticism of Informed Consent for developing into a legalistic concept or encouraging ‘defensive medicine’ among physicians, Shared Decision-making has been introduced as a more interactive approach towards implementing the physician’s respect for the patient’s wishes and needs (van Nistelrooij et al. 2017). Both concepts, Informed Consent and Shared Decision-making could hardly be more prominent in patient care (Whitney et al. 2004). If their nature, content and context of justification as ‘ethics’

are not recognized, this ubiquitous ethical aspect of clinical practice will be overlooked in both research and daily clinical routine.

In the studies on cross-cultural clinical practice found in our own accompanying literature review during the course of this study, ‘low threshold’ ethical issues in migrant health are neither identified nor articulated. Thus, there seem to be difficulties in recognizing ethical problems in cross-cultural clinical practice that are not necessarily dramatic but still obvious. This is especially true compared to perceived ethical issues that are connected to difference of origin, be it in culture, religion, language or another, and their implications for a principles-based approach (Ilkilic 2007; Ilkilic and Ertin 2017; Minkoff 2014).

The patients included in this study and their clinical encounters did trigger ethical issues - in the observer / researcher. But none of these cases had led to ethical reflection or even a request for ethics support, despite the service’s availability at the USB (Reiter-Theil and Schürmann 2016). This corroborates the assumption that a link between specific topics in migrant health and ethics (support) has not yet been successfully established in clinical practice. Besides encouraging further studies, this insight could also stimulate ethics support services to more pro-actively address issues in this field.

The contribution of the empirical domain towards medical ethics as well as the relevance of everyday ethical issues have been emphasized by Reiter-Theil and others before (Kearney and Penque 2012; Reiter-Theil 2012). The implicit ethical dimension of clinical practice as such, beyond perceived ethical conflict or dilemma, has also been addressed earlier by diverse authors using different terms, such as “everyday ethics” (Powers 2001; Zizzo et al. 2016) or “micro-

ethics” (Komesaroff 1995; Truog et al. 2015). Our findings strengthen previous work in this field, revealing subtle issues in everyday cross-cultural clinical practice which are below the threshold of what is generally being perceived as (ethically) relevant and therefore often neglected in medical ethics’ analysis. This includes ambiguities and uncertainties resulting in ‘getting by’ (II), difficulties in perceiving the other as tangible (III) or a neglect of social aspects (III). However, as Komesaroff (1995) claims, “crucial ethical issues are involved [...] in those clinical decisions which appear at first sight to be the simplest and most straight forward” (Komesaroff 1995).

Besides a mere recognition of the often nuanced and subtle nature of ethical issues in cross-cultural clinical practice, reducing disadvantages of patients with migration background is intrinsically linked with the question of responsibility (for action), fairness and justice. While social institutions and policy adopt this task at a macro level of society (e.g. health policies), this question is more complex within the micro world of an individual clinical encounter. This is even more so when ethical issues are at risk of being overlooked or not being recognized, for example because involved issues “occur often and affect the many” (Zizzo et al. 2016) - which is typical for everyday ethical issues (Zizzo et al. 2016). Yet, an examination of responsibility needs to be preceded by the understanding that problems exist (instead of e.g. ‘merely’ difficulties (III)) having real consequences. Here, an explicit acknowledgement of ethics could contribute to a shift in perception, by what Ahola-Launonen (2015) calls an “evolving idea of social responsibility in bioethics” (Ahola-Launonen 2015). The concept of social responsibility critically looks at a mere individualistic view on individuals’ health which is also reflected in the overall individualistic tradition of medical history, placing the individual’s responsibility for his/ her own health in the centre and leaving social determinants as a side question. However, as “so many

determinants of health are beyond the individual's control" (Ahola-Launonen 2015), e.g. social or political ones, a call for medical ethics to take the social context stronger into account has been made, arguing that "holding individuals solely responsible for their own health is not a fair conclusion" (Ahola-Launonen 2015). Acknowledging the social embeddedness of health could contribute to a climate in medicine where responsibilities are more widely spread and where the social perspective is accepted as an integral part of what is considered relevant for health. For example, in the context of specific clinical interactions, the topic of responsibility was derived from questions about responsibility and duty of care towards a patient in need: (when) is it allowed to stop trying? For example, there are assumptions that a patient does not follow treatment instructions because he/ she is fixated on own ideas. This is suggestive of being the end of efforts to find a solution for this situation and explore other ways to overcome barriers to effective treatment (III) or the responsibility to reach a shared understanding so that the patient can make an informed choice (III).

3. Strengths and weaknesses of this research

In this study, we revealed new and crucial aspects of daily cross-cultural clinical encounters and provided an in-depth understanding of patients' and physicians' experiences. The long-term engagement in the research field, including participant observation and semi-structured interviews and triangulation of perspectives, enabled us to explore in detail what mattered to patients and healthcare professionals themselves in their interactions, and which meaning they gave to their perceptions within the context of the clinical setting. As a qualitative study it collected numerous and rich data using an innovative and extensive design of triangulation. It

proved to be a merit of the study to actually involve patients and HCPs as individuals rather than collecting data *on them*.

Besides these strengths, the study has weaknesses. First, the question whether our findings have any bearing beyond the specific setting in which this study took place remains open. However, several efforts were undertaken to strengthen the validity of the results. On the one hand, the different strategies we used (e.g. triangulation of different data sources, different data collection methods, self-reflexivity, long-time presence at the setting during fieldwork) ensure trustworthiness of our findings (Hadi and José Closs 2016). On the other hand, the areas of interest that we reported reflect those that are mentioned in the literature.

Second and associated to the first, we do not know whether our study would have led to different results with migrants from other origins. However, assuming that language is a central element of a person's cultural identity (Senft 2013) we used this criterion to identify a certain population that might yield interesting observations of cross-cultural clinical encounters. Furthermore, this choice also corresponds to the frequency distribution of patients presenting themselves to outpatient services at Basel University Hospital and to the request for languages in interpreter services.

A third aspect worth considering is related to the differences in social characteristics within the study population, especially between patients and physicians, as they build the groups whose data are presented here. In general, compared to physicians, patients' educational level and German proficiency were rather low. This imbalance in language proficiency and educational background among the participants raises doubts whether all participants had principally been

able to express their views equally well or whether migrants' views might fall short. Coming from a pragmatic approach, the use of observational data during interviews, and informal talks with patients (e.g. in the waiting area) may have partially counterbalanced this. However, we did not intend to compare views seen as identical entities to portray 'the truth' about cross-cultural clinical encounters; such claims are not the aim of ethnographic research, and conflict with its epistemic foundation in constructivism. Instead, an important interest of our research was to understand how the different groups and individuals give meaning to the experiences they made and described (e.g. patients, physicians, researcher).

IV. Conclusion

The objective of this PhD study was to investigate how migrant patients and healthcare professionals experience communication and interaction in their shared clinical encounters and to explore and reflect upon ethical aspects involved. A number of answers and conclusions are presented in this thesis. In general, the results point to the importance of subtle issues in everyday clinical practice which are often below the threshold of what is generally associated with/ being perceived as important/relevant in cross-cultural clinical encounters.

First, we have shown that perceptions of openness and mutuality can be decisive aspects in a clinical relationship and contribute to perceptions of a successful clinical encounter despite circumstances with potential for misunderstandings. Furthermore, we have shown the value of (self-) reflection, in order to become aware of one's own biases and to gain new insights into actions that normally happen automatically.

Second, we could provide a deeper understanding of the complexity of decision-making surrounding patients' limited language proficiency in cross-cultural clinical encounters ('getting by'). We have also shown that connected ethical implications, e.g. regarding the quality of care, are often not recognized by physicians, the key stakeholders in initiating the process of medical interpreting. We suggested the development of a conceptual framework close to practice for guiding physicians' assessment of patients' language proficiency and their decision-making on the use of interpreting services.

Third, we have highlighted the importance of concordance and clinical relationships for both, patients and physicians. Taking the proven links between migration background and inequalities in health, insights provided are crucial to better understand what the difficulties on the

individual level of a cross-cultural clinical encounter are. The social embeddedness of health plays an important role here and should be better acknowledged by both, ethics and medicine. Ethics in hospital could contribute to a much needed shift in perception: from seeing 'simple' difficulties to understanding that *problems* exist having real consequences (Reiter-Theil and Schürmann 2016).

Future research should continue to investigate cross-cultural clinical encounters from different perspectives and analyze data from different professional groups involved (e.g. nursing staff, front desk staff) including different hospital settings (e.g. including in-patients) to validate the results of this dissertation or identify additional relevant aspects. Herewith, despite already existing movements in that direction, a stronger willingness to engage in the often subtle and nuanced nature of involved issues instead of falling into the trap of generalization and 'culturalization' would be much needed.

For example, future studies might further investigate how stance in general, but also concepts like cultural or narrative humility and self-reflectiveness contribute to the success of a cross-cultural clinical encounter and counterbalance an unreflective notion of the term 'culture' in medical settings.

Regarding language barriers further work is needed to make the complexities in physicians' decision-making, the key element in the practice of 'getting by', more visible. In this context, it will be important that the concrete consequences of these decisions are examined in terms of their impact on treatment and health outcomes. Additionally, patients' views need to be further explored to better understand the factors driving their decisions for or against the use of professional interpreter services.

Finally, it will be important that future research investigates concordance and relationship issues in the specific setting of cross-cultural clinical encounters, for example by exploring if or how they are (perceived to be) connected and implications for future interventions.

Ethical reflection on current practice in cross-cultural clinical encounters should contribute more actively to putting the often subtle and inconspicuous everyday issues into focus, rather than focusing the dramatic aspects, to stimulate an environment in healthcare where recognition of such issues is facilitated to healthcare professionals. This would provide a good starting point enhancing a transparent discussion about experienced difficulties within that field and normative ethical implications, especially in view of the social embeddedness of health and existing health inequalities. In general, medical ethics research on migrant health urgently needs interdisciplinary approaches to be able to cope with the complexity of involved issues.

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Appendices

Interviewleitfaden für PatientInnen

Einleitung Interview

Ich möchte noch mal mit Ihnen die Situation gestern/ heute anschauen. Mir geht es darum zu erfahren, wie Sie den Aufenthalt im Spital erlebt haben. Das Gespräch wird aus zwei Teilen bestehen. Im ersten kürzeren Teil werde ich Sie nach einigen persönlichen Daten, z.B. ihrer Nationalität, fragen. Im zweiten Teil werde ich Ihnen zu den einzelnen Stationen Ihres heutigen Tages im Spital Fragen stellen. Ich werde dabei der Reihenfolge nach vorgehen und mit der Ankunft im Spital beginnen, hin zum Empfang, danach zur Pflege, bis hin zur Konsultation. Zuletzt werde ich Ihnen noch einige abschliessende Fragen stellen. Bitte antworten Sie ganz frei, alles was Sie sagen ist interessant für mich. Ich werde, wenn ich etwas nicht verstanden habe, nachfragen. Das Interview wird ca. 1 Stunde dauern.

Persönliche Daten

Name:

Vorname:

Geburtsdatum:

Geburtsort:

Familienstand:

Nationalität:

Seit wann in der Schweiz:

Herkunftsland der Eltern:

In welcher Sprache sprechen Sie überwiegend:

In welcher Sprache lesen Sie überwiegend:

Schulbildung:

Berufstätigkeit:

Datum Konsultation:

Grund Konsultation:

Patientenprozess

Ankunft Spital (Einstieg)

Wenn man im Spital ankommt, muss man sich ja erst einmal zurechtfinden. Können Sie mir erzählen wie es Ihnen da ergangen ist, welche Erfahrungen Sie gemacht haben?

1. *Teilnehmende Beobachtung:*

- Gab es etwas was Ihnen bei der Orientierung geholfen hat?
 - Wie war das mit den Hinweisschildern für Sie? **PAUSE.** *Ggf.* Haben die weitergeholfen?
 - Wie war das für Sie am Informationsschalter? **PAUSE.** *Ggf.* Wie hilfreich waren die Informationen die Sie dort bekommen haben?
 - [Sie hatten ja eine Informationsbroschüre dabei. Was hat denn die gebracht?]
 - Ich habe gesehen, dass Sie sich im Spital schon ganz gut auskennen. **PAUSE.** Wie war es als Sie das erste Mal im Spital waren, können Sie sich noch erinnern wie das mit der Orientierung war?

2. *Spezifische Fragen*

- Wie haben Sie eigentlich den heutigen Termin vereinbart?
 - Und wie verständlich war das Gespräch mit [...] für Sie gewesen?
 - Welche Informationen hatten Sie über die Möglichkeit eines Dolmetschers erhalten?
(fällt weg, wenn PatientIn gut deutsch spricht)

Zusammenfassende Aufzählung, die auf die guten und schlechten Situationen eingeht. Abwarten was die Patientin aufgreift. Verifizieren durch nachfragen.

Administration

Jetzt interessiert mich wie Sie die Anmeldesituation erlebt haben:

1. *Teilnehmende Beobachtung:*

- Ich hatte den Eindruck, es war für Sie nicht alles klar was die Mitarbeiterin am Empfang von Ihnen benötigt hat/ von Ihnen wissen wollte. Wie ist es Ihnen da ergangen/ worin lag für Sie die Schwierigkeit?
- Ich hatte den Eindruck, Sie hatten Mühe mit dem Formular. Erzählen Sie doch mal.
- Ich hatte den Eindruck es war für Sie nicht klar/ nachvollziehbar/... warum Sie [z.B] so lange warten mussten. Wie war das aus ihrer Sicht/ welche Informationen hatten Sie da bekommen?

- Ich hatte den Eindruck, dass Ihnen das weniger gefallen hat/ sie das besonders gut fanden. **PAUSE.** Was hätten Sie denn da erwartet/ hatten Sie denn da mit etwas anderem gerechnet? **PAUSE.** Womit hatten Sie denn gerechnet?
- Schildern Sie bitte wie Sie das am Empfang erlebt haben. *Wenn dann etwas kommt nachhaken.*

2. Spezifische Fragen

- Wie war es für Sie mit der Verständigung am Empfang?
 - Hatten Sie den Eindruck, dass die MitarbeiterIn sich in Bezug auf die Sprache auch auf Sie einstellt/ sich Ihnen anpasst? Woran haben Sie das gemerkt? (*Wenn Sprache Thema ist*)
 - Welche Formulare gab es in Ihrer Sprache?
 - Welche anderen Informationsmaterialien haben Sie erhalten?
 - Hatten Sie den Eindruck, dass die MitarbeiterIn berücksichtigt/ gemerkt hat, dass Sie mit der [z.B. Vorgehensweise bei Arbeitsunfällen] nicht so vertraut sind? Woran haben Sie das gemerkt?
 - Als die MitarbeiterIn Ihnen Auskunft über [organis. Ablauf] gegeben hat, wie verständlich war das für Sie?
- Ich frage mich manchmal, ob man bei der Anmeldung gut darauf vorbereitet ist, PatientInnen in Empfang zu nehmen, die aus der Türkei/ Albanien kommen. **PAUSE.** (Oder die vielleicht nicht so gut deutsch sprechen). **PAUSE.** Was meinen Sie dazu?
- Wenn Sie etwas verändern könnten, was würden sie verändern?
- Gab es etwas was Ihnen am Empfang unangenehm war?
 - War das eigentlich das Unangenehmste (oder so ähnlich), was Ihnen hier passiert ist?
 - Was könnte man machen, damit das nicht wieder passiert?
- Gab es etwas was Sie sehr geschätzt haben am Empfang?

Zusammenfassende Aufzählung, die auf die guten und schlechten Situationen eingeht. Abwarten was die Patientin aufgreift. Je nach Angaben verifizieren durch nachfragen.

- Ergänzen Sie bitte, wenn ich etwas Wichtiges vergessen habe.

Pflegerische Massnahmen

Kommen wir zum Thema Pflege.

1. Teilnehmende Beobachtung

- Mir ist aufgefallen, dass Sie (ab und zu)
 - War ihnen klar warum [...]?
 - Ich hatte den Eindruck, dass Ihnen diese Situation unangenehm/ peinlich war. **PAUSE.** [Reaktion abwarten] Was war Ihnen denn unangenehm?

- Ich könnte mir vorstellen, dass das schmerzhaft für Sie war. **PAUSE.** [Reaktion abwarten] Wie war das für Sie wie die Pflegende da reagiert hat?
- Ich hatte den Eindruck, dass Ihnen das überhaupt nicht gefallen hat/ sie das besonders gut fanden. **PAUSE.** Womit hätten Sie denn gerechnet/ hatten Sie denn da mit etwas anderem gerechnet? **PAUSE.** Womit hatten Sie denn gerechnet? Ich hatte den Eindruck, dass das eine schwierige Situation für Sie war. **PAUSE.** [Reaktion abwarten] Wie sind Sie damit umgegangen?
- mit der Pflegenden auch kurz über [privates Thema] gesprochen haben.
 - War das für Sie wichtig, sich ein bisschen „normal“ zu unterhalten? **PAUSE.** Warum?
 - Was denken Sie, woran hat das gelegen, dass Sie auch über Privates gesprochen haben?
- Erzählen Sie doch mal wie das da bei der Pflege abgelaufen ist. *Wenn dann etwas kommt nachhaken.*

2. Spezifische Fragen

- Ich habe von anderen Patienten aus der Türkei/ Albanien schon gehört, dass man bei der Pflege nicht so gut darauf vorbereitet ist Menschen zu betreuen die eine andere Kultur haben. **PAUSE.** (Oder die nicht so gut Deutsch sprechen). **PAUSE.** Was meinen Sie dazu?
 - Die Pflegende hat ja immer mal wieder gesagt was Sie gerade macht/ Ihnen verschiedene Anweisungen gegeben, während Sie die [pflegerische Verrichtung] gemacht hat. **PAUSE.** Welche Informationen waren für Sie hilfreich und verständlich und wo hatten Sie eher Verständnisschwierigkeiten?
 - Für die [pflegerischen Verrichtung] muss man ja [z.B. sich frei machen]. **PAUSE.** Wie haben Sie diese Situation erlebt? **Wenn nicht schon angesprochen:** Gab es etwas was Ihnen bei der Pflege unangenehm war? Was war das?
 - ist das eigentlich das Unangenehmste (oder so ähnlich), was Ihnen hier passiert ist?
 - Was könnte man machen, damit das nicht wieder passiert?
 - **Wenn nicht schon angesprochen:** Gab es etwas was Sie sehr geschätzt haben? Was war das?
 - Wenn Sie bei der Pflege etwas verändern könnten, was würden Sie verändern?
- Zusammenfassende Aufzählung, die auf die guten und schlechten Situationen eingeht. Abwarten was die Patientin aufgreift. Je nach Angaben verifizieren durch nachfragen.*
- Ergänzen Sie bitte, wenn ich etwas Wichtiges vergessen habe.

Ärztliche Konsultation/ Untersuchung

Jetzt wüsste ich gerne noch, wie Sie das Gespräch mit Dr. ... erlebt haben. Erzählen Sie doch einfach mal!

1. Vertiefung durch Ansprechen von Beobachtetem:

- Mir ist aufgefallen, dass Sie (ab und zu) **PAUSE.**

- Ich hatte den Eindruck, dass es eher schwer verständlich für Sie war, was die Ärztin/ der Arzt da gesagt hat. **PAUSE.** [Reaktion abwarten]. Was war denn der Grund dafür, dass Sie da Schwierigkeiten hatten?
 - Und wie war das für Sie wie der Arzt/ die Ärztin da reagiert hat?
- Gab es Ihrer Meinung nach Schwierigkeiten die über die sprachliche Verständigung hinausgegangen sind? Welche waren denn das?
- War Ihnen dieses Thema/ diese Frage unangenehm? **PAUSE.** [Antwort abwarten]. Was war Ihnen denn unangenehm?
 - Und wie war das für Sie wie der Arzt/ die Ärztin da reagiert hat?
- Wie war es für Sie, dass der Arzt/ die Ärztin mit Ihnen über [...] sprechen wollte?
- Haben Sie sich gewundert, dass dieses [...] Thema angesprochen wurde? **PAUSE.** [Antwort abwarten]. Warum hat Sie das denn überrascht?
- Ich könnte mir vorstellen, dass es nicht ganz einfach ist vor [...] über [...] zu sprechen/ Fragen zu beantworten. **PAUSE.** Wie war denn das für Sie?
- Ich hatte den Eindruck, dass Dr. [...] während des Gesprächs sehr viel gesprochen hat und Sie selbst wenig Gelegenheit zu sprechen hatten. **PAUSE.** [Reaktion abwarten]. Welche Erfahrungen haben Sie da gemacht?
- Ich könnte mir vorstellen, dass es nicht unbedingt angenehm ist wenn man als Frau/ Mann mit einem männlichen/ weiblichen Arzt über [...] sprechen soll. Wie haben Sie das empfunden?

Ich hatte den Eindruck, dass Ihnen das überhaupt nicht gefallen hat/ sie das besonders gut fanden. **PAUSE.** Was hätten Sie denn erwartet/ hatten Sie denn da mit etwas anderem gerechnet? **PAUSE.** Womit hatten Sie denn gerechnet?

2. Spezifische Fragen

- Wie war das Gespräch von der Verständlichkeit her für Sie?
- In dem Gespräch sind ja verschiedene Punkte angesprochen worden, was war für Sie besonders wichtig?
- Ich könnte mir vorstellen, dass es nicht ganz einfach ist über [...] zu sprechen/ Fragen zu beantworten. **PAUSE.** [Reaktion abwarten]. Wie ist es Ihnen da ergangen?
 - Und wie war das für Sie wie der Arzt/ die Ärztin da reagiert hat?
- Haben Sie den Eindruck, dass Sie alles besprechen konnten, was Ihnen wichtig war? **PAUSE.**
 - Oder sind Themen offen geblieben, über die Sie gar nicht geredet haben?
 - Was war das z.B.?
 - Warum haben Sie dieses Thema nicht angesprochen?
- Hatten Sie den Eindruck, dass die Ärztin/ der Arzt auch Ihre familiäre/ berufliche/[...] Situation mitbedenkt? [Antwort abwarten] Woran haben Sie denn das gemerkt?
- Welche Fragen/ Themen hätte die Ärztin/ der Arzt aus Ihrer Sicht auch ansprechen/ berücksichtigen sollen?
- **Wenn nicht schon angesprochen:** Gab es etwas was Ihnen während des Gesprächs unangenehm war? Was war das?
 - Was könnte man machen, damit das nicht wieder passiert?
- **Wenn nicht schon angesprochen:** Gab es etwas was Sie sehr geschätzt haben? Was war das?

Der Arzt/die Ärztin hat Sie ja auch körperlich untersucht. Wie war das denn für Sie?

1. *Teilnehmende Beobachtung:*

- Mir ist aufgefallen, dass Sie (ab und zu) **PAUSE**.
 - Ich hatte den Eindruck, dass Ihnen diese Situation unangenehm/ peinlich war. **PAUSE**. [Reaktion abwarten] Was war Ihnen denn unangenehm?
 - Und wie war das für Sie wie der Arzt/ die Ärztin da reagiert hat?
 - Ich könnte mir vorstellen, dass das schmerzhaft für Sie war. **PAUSE**. [Reaktion abwarten] Wie war das für Sie wie der Arzt/ die Ärztin da reagiert hat?
 - Ich könnte mir vorstellen, dass es nicht unbedingt angenehm ist, wenn man als Frau/ Mann von einem männlichen/ weiblichen Arzt körperlich untersucht wird. **PAUSE**. [Reaktion abwarten]. Wie haben Sie das empfunden?
 - Ich hatte den Eindruck, dass Ihnen das überhaupt nicht gefallen/besonders gut gefallen hat. **PAUSE**. [Reaktion abwarten]. Was hätten Sie denn erwartet? / hatten Sie denn da mit etwas anderem gerechnet? **PAUSE**. Womit hatten Sie denn gerechnet?

2. *Spezifische Fragen*

- **Stellen Sie sich vor: Sie hören wie ein Arzt zu einem Kollegen sagt „Die Patienten aus Albanien/ der Türkei, ich kapiere irgendwie nicht“. Was würden Sie da denken in dem Moment?**
 - Als der Arzt/ die Ärztin Ihnen gesagt hat dass er/ sie [...] machen wird, wie verständlich war das für Sie? Wussten Sie dann Bescheid was auf Sie zukommt?
 - Haben Sie sich manchmal gewundert, warum der/die ... untersucht? [Antwort abwarten] *Ggf.* Warum hat Sie das gewundert?
 - Haben Sie manchmal gedacht, dass der/die etwas Anderes auch noch hätte untersuchen sollen? [Antwort abwarten] *Ggf.* Was wäre denn das? [Antwort abwarten] Und warum denken Sie, hätte [...] auch noch untersucht werden müssen?
 - Was sagen eigentlich andere Menschen die Sie kennen dazu, ob die Ärzte hier im Spital gut darauf **vorbereitet** sind, PatientInnen zu behandeln, die eine andere Kultur haben? **PAUSE**. (Oder die nicht so gut deutsch sprechen?)
 - Wissen Sie jetzt, was Ihnen gefehlt hat?
 - Wissen Sie jetzt, wie es gesundheitlich mit Ihnen weitergeht?
 - Worauf Sie achten müssen, z.B. damit es nicht noch mal so weit kommt?
- Zusammenfassende Aufzählung, die auf die guten und schlechten Situationen eingeht. Abwarten was die Patientin aufgreift. Je nach Angaben verifizieren durch nachfragen.*
- Ergänzen Sie bitte, wenn ich etwas Wichtiges vergessen habe.

Verlassen des Spitals

Wie ist das jetzt für Sie, wo Sie das Spital verlassen. Erzählen Sie doch einfach mal!

1. *Teilnehmende Beobachtung*

- Wie ist es für Sie mit dem Termin am [Datum], wo müssen Sie denn da hin?

- Und was wird dann dort gemacht?
- Ich hatte den Eindruck, dass es mit dem Deutschsprechen nicht ganz leicht für Sie war. Was wissen Sie darüber wie es beim nächsten Termin gemacht wird damit es besser läuft?

2. *Spezifische Fragen*

- Haben Sie denn den Eindruck, Sie kommen jetzt wieder klar zu Hause und bei der Arbeit?

Zum Schluss

- Wie sehen Sie das, in welchem Mass ist das Spital darauf eingerichtet Menschen zu betreuen die eine andere Kultur haben (oder eine andere Sprache sprechen)?
- Gibt es aus Ihrer Sicht noch wichtige Dinge die bisher nicht angesprochen wurden?

*Interviewleitfaden für MitarbeiterInnen **ÄrztInnen***

Persönliche Daten

Name:

Vorname:

Geburtsdatum:

Geburtsort:

Familienstand:

Nationalität:

Wenn CH

Nationalität der Eltern:

Wenn nicht CH

Seit wann leben Sie in der Schweiz:

Sprechen sie andere Sprachen ausser Deutsch?

Wenn ja

Welche anderen Sprachen sprechen Sie?

Sprechen Sie diese Sprache(n) gut genug für die ärztliche Behandlung von Patienten?

Abteilung:

Einstieg

Mich interessiert wie Sie die Konsultation mit Frau/ Herrn [Name] erlebt haben.

Konsultationsgespräch

Teilnehmende Beobachtung

- Mir ist aufgefallen, dass [...]
 - Ich hatte den Eindruck, dass die Verständigung mit Frau/ Herr [Name] nicht ganz einfach war. PAUSE. [Reaktion abwarten]
 - Was haben Sie da gemacht?
 - Welchen Eindruck hatten Sie, wie das für die Patientin/ den Patienten war?
 - Hatten Sie den Eindruck, dass die Patientin verstanden hat was Sie ihr mitteilen wollten? Woran haben Sie das denn gemerkt?
 - Mir ist aufgefallen, dass Sie [...]. Aus welchem Grund haben Sie das denn gemacht?
 - Haben Sie Herausforderungen erfahren, die über die sprachliche Verständigung hinausgegangen sind? Welche waren das?
 - Hatten Sie den Eindruck, dass das Thema [...] der Patientin/ dem Patienten unangenehm war?
 - Woran haben Sie das gemerkt?

- Und wie sind Sie damit umgegangen?
- War es für Sie nachvollziehbar, dass die Patientin mit Ihnen auch über [Thema] sprechen wollte? Warum war das für Sie nachvollziehbar/ nicht nachvollziehbar?
- Ich hatte den Eindruck, dass Ihnen das weniger/ besonders gut gefallen hat. PAUSE. Wie haben Sie das erlebt?
- Hatten Sie den Eindruck, dass es für die Patientin eine Rolle gespielt hat, ob sie mit einem männlichen oder einem weiblichen Arzt über [Thema] spricht? Woran haben Sie das gemerkt?
- Ich hatte den Eindruck, dass es für Frau/ Herr [Name] nicht leicht war mit Ihnen über [Thema] zu sprechen. PAUSE. [Reaktion abwarten]
 - Was haben Sie da gemacht?
 - Was denken Sie, woran könnte das gelegen haben?

Spezifische Fragen

- Ich könnte mir vorstellen, dass man manchmal erst herausfinden muss wie man sich mit jemandem am besten verständigen kann. Wie war das bei Ihnen und Frau/ Herr [Name]?
- Was denken Sie, wie hat Frau/ Herr [Name] das Konsultationsgespräch erlebt?
- In dem Gespräch sind ja verschiedene Punkte angesprochen worden, was war für Sie besonders wichtig?
- Konnten Sie von der Patientin/ dem Patienten alles erfahren was für Sie wichtig ist?
- Hatten Sie den Eindruck, dass die Patientin/ der Patient alles verstanden hat was Ihnen wichtig war? Woran haben Sie das gemerkt?
- Gab es für Sie in diesem Konsultationsgespräch spezielle kulturelle/ soziale Aspekte? Welche waren das?
- Wenn die sprachliche Verständigung mit einer Patientin/ einem Patienten nicht möglich ist, wie gehen Sie dann vor?
- Gab es Momente bei denen Sie den Eindruck hatten, dass Frau/ Herr [Name] sie als besonders schwierig/ unangenehm erlebt hat? Woran haben Sie das gemerkt?
- Gab es etwas, was Ihnen während der Begegnung mit Frau/ Herr [Name] besonders positiv/weniger positiv aufgefallen ist?
- Gibt es etwas, was über das bisher Besprochene hinausgeht und Ihnen in der Begegnung mit Patienten, die wie Frau/ Herr [Name], einen Migrationshintergrund haben, regelmässig auffällt?

Wenn Dolmetscher anwesend:

Ich möchte gerne noch mit Ihnen über die Dialogsituation mit der Dolmetscherin/ dem Dolmetscher sprechen.

- Wie haben Sie den Dialog erlebt?
 - Gab es etwas was Ihnen besonders positiv aufgefallen ist?

- Gab es Momente die Sie als schwierig/ unangenehm erlebt haben? PAUSE. Welche waren das?
- Haben Sie während Ihrer Tätigkeit am USB eine Fort-/Weiterbildung zum „Trialog“ erhalten? Wenn ja, in welchem Zusammenhang? War diese Fort-/Weiterbildung hilfreich?

Körperliche Untersuchung

Teilnehmende Beobachtung

- Mir ist aufgefallen, dass [...]
→ Hatten Sie den Eindruck, dass sich Frau/ Herr [Name] in dieser Situation unwohl/ beschämt gefühlt hat?
 - Woran haben Sie das gemerkt?
 - Was denken Sie was der Grund dafür war?
 - Konnten Sie mit dieser Situation gut umgehen? Wie?
- Ich könnte mir vorstellen, dass Frau/ Herr [Name] Ihnen da mitteilen wollte, dass [...] für sie schmerzhaft war. PAUSE. [Reaktion abwarten]
 - Wie haben Sie das erlebt?
 - Was haben Sie da gemacht?
- Hatten Sie den Eindruck, dass es für die Patientin eine Rolle gespielt hat, ob sie ein männlicher oder ein weiblicher Arzt untersucht? Woran haben Sie das gemerkt?
- Mir ist aufgefallen, dass Sie [...]. Aus welchem Grund haben Sie das denn gemacht?
- Ich hatte den Eindruck, dass Ihnen da gar nicht wohl war/ Sie das gefreut hat. PAUSE. Was hätten Sie erwartet/ was haben Sie im Vorfeld befürchtet?
- Was denken Sie, wie hat Frau/ Herr [Name] das [Besprochene] erlebt?
- Gab es für Sie während der körperlichen Untersuchung spezielle kulturelle Aspekte? Welche?

Spezifische Fragen

- Sie haben Frau/ Herrn [Name] immer wieder gesagt was Sie gerade machen/ verschiedene Anweisungen gegeben. Hatten Sie den Eindruck, dass Frau/ Herr [Name] das verstanden hat? Woran haben Sie das gemerkt?
- Ich kann mir vorstellen, dass man im Bewusstsein um sensible Themen (z.B. Körperkontakt) an eine körperliche Untersuchung bei einem Patienten wie Frau/ Herr [Name] anders herangeht. Wie ist das für Sie?
- Was denken Sie, wie hat Frau/ Herr [Name] die körperliche Untersuchung erlebt?
- Haben Sie den Eindruck, dass man unter den Ärzten gut darauf vorbereitet ist PatientInnen zu behandeln, die Schwierigkeiten mit der deutschen Sprache haben oder aus einer anderen Kultur kommen? Woran machen Sie das fest?

- Wenn Sie organisatorisch etwas verändern könnten, was würden sie verändern?
- Gab es etwas, was Ihnen während der Begegnung mit Frau/ Herr [Name] besonders positiv aufgefallen ist?
- Gab es Momente die Sie als eher schwierig/ unangenehm erlebt haben? PAUSE. Was haben Sie da gemacht?
- Gab es Momente bei denen Sie den Eindruck hatten, dass Frau/ Herr [Name] sie als eher schwierig/ unangenehm erlebt hat? Woran haben Sie das gemerkt?
- Gab es allgemeine Situationen mit Frau/ Herr [Name], die sie als typisch erleben?
- Gibt es etwas, was über das bisher Besprochene hinausgeht und Ihnen in der Begegnung mit Patienten, die wie Frau/ Herr [Name], einen Migrationshintergrund haben, regelmässig auffällt?

Zum Schluss

- Wie sehen Sie das, in welchem Mass ist das Spital darauf eingerichtet Menschen zu betreuen die einen anderen kulturellen oder sprachlichen Hintergrund haben?
- Mir ist aufgefallen, dass oft relativ schnell von Kultur gesprochen wird und ich frage mich manchmal was eigentlich genau damit gemeint wird. (PAUSE) Was heisst denn das für *Sie* im Kontext ihres klinischen Alltags?
- Gibt es aus Ihrer Sicht noch wichtige Dinge die bisher nicht angesprochen wurden?
- Was wäre ihr grösstes Anliegen was besser gemacht werden könnte?
- Worin besteht für Sie die grösste Herausforderung bei Patienten mit Migrationshintergrund?

Zusammenfassende Aufzählung, die auf die guten und schlechten Situationen eingeht. Abwarten was die Mitarbeiterin/ der Mitarbeiter aufgreift. Verifizieren durch nachfragen:

- War das eigentlich das Unangenehmste (oder so ähnlich), was Ihnen hier passiert ist?
 - Was könnte man machen, damit das nicht wieder passiert?
- War das für Sie so gut?

Dolmetscherdienst nutzen

Allgemeine Regeln

Für Alltagsgespräche können Begleitpersonen und ungeschulte Mitarbeitende als Ad-hoc-Dolmetschende eingesetzt werden.

Kinder unter 16 Jahren sind nur im absoluten Notfall und auf ausdrücklichen Wunsch einer Patientin oder eines Patienten als Dolmetschende einzusetzen.

Professionelle Dolmetschende (eingeschlossen darin geschulte Mitarbeitende) sind zu nutzen, wenn es über Alltagsgespräche hinaus geht.

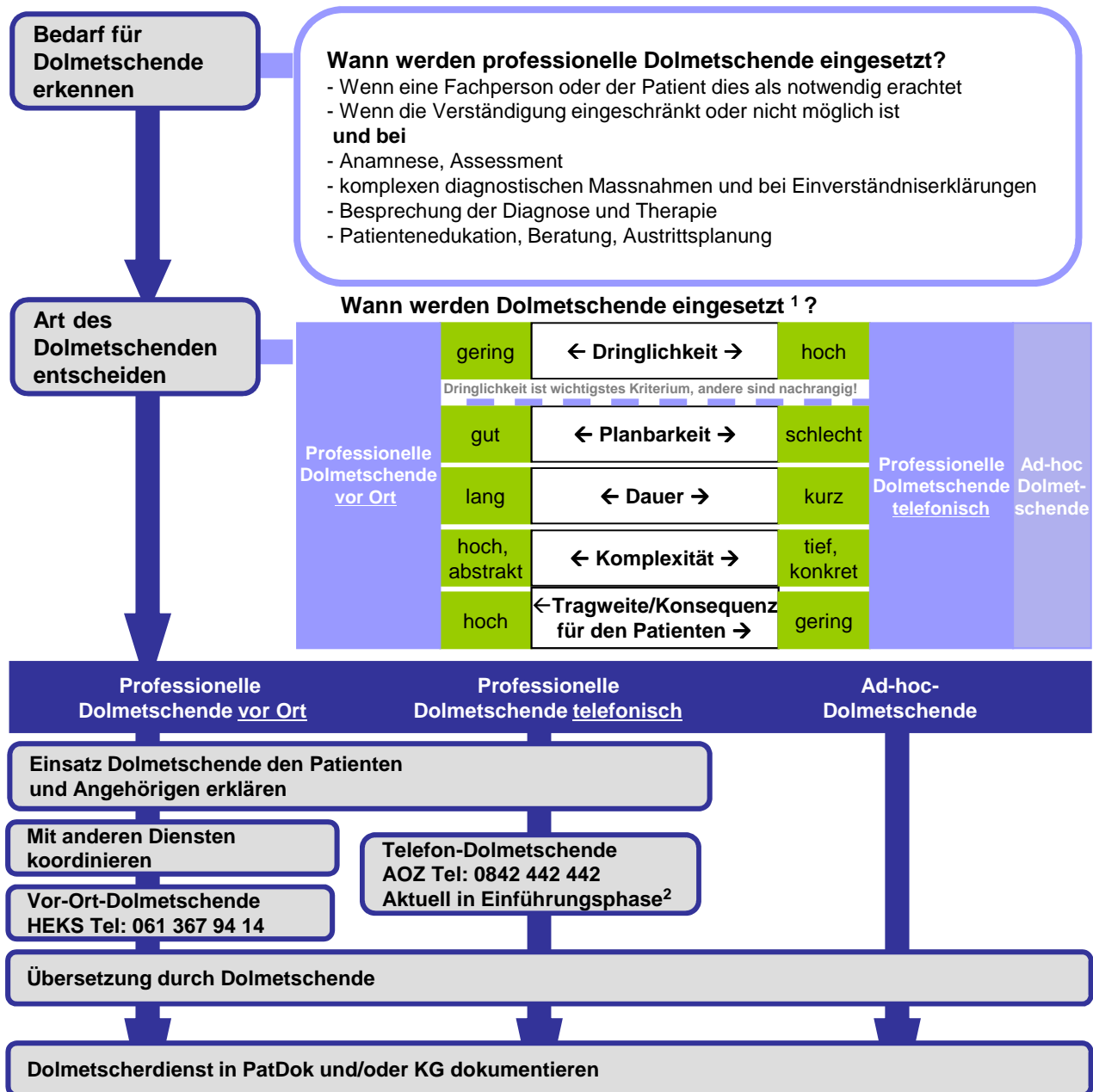
Prozess-Ziel

Das **professionelle Vorgehen** bezüglich Kommunikation und Übersetzungsauftrag bei fremdsprachigen Patienten zur Unterstützung von erfolgreichen Behandlungsteams **ist definiert** und wird angewendet.

Unterstützter Wert des USB

„Wir begegnen unseren Patienten mit Wertschätzung und geben ihnen die gewünschten Informationen“

Ablauf



1) In Anlehnung an Bischoff, Steinauer & Kurth, (2006). Dolmetschende im Spital, Institut für Pflegewissenschaft, Universität Basel
 2) Weitere Informationen bei Dr. S. Schuster, Programmleiterin
 Handlungsleitfaden erstellt durch V. Biemann, N. Awad, M.L. Daly, Projekt: „Migration und Gesundheit: Diversität und Chancengleichheit am Universitätsspital Basel“, 12/2011, modifiziert durch Dr. S. Schuster 4/2016

Curriculum Vitae

Kristina Maria Würth

Research and Work experience

August 2018 to date	Mentee Clinical Ethics Support Service, Department Clinical Ethics, University Hospital Basel/ Psychiatric Hospitals University Basel.
January 2011 to December 2017	Research collaborator at the University Hospital Basel Program “Diversity Management” in collaboration with the Federal Office of Public Health.
October 2015 to September 2016	Research collaborator at “Project on clinical decision-making at the University Hospital Basel” (in collaboration with Massachusetts General Hospital, Boston)
2010-2012	Calcutta Project Basel: Program Monitor for “Public Health in Prostitute Area” (PHPA).

Education

January 2011 to date	PhD Student in Medical and Health Ethics at the University of Basel (Dr. sc. med).
December 2008	Licentiate in Cultural Anthropology at the University of Basel
June 1999	Baccalaureate at the “Hans-Thoma Gymnasium” in Lörrach, Germany.

Publications

Wuerth, K., Schuster, S.	<i>“Some of them shut the door with a single word, but she was different” – A migrant patient’s culture, a physician’s</i>
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narrative humility and a researcher's bias. Patient Educ. Couns. 100 (2017) 1772-1773.

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Langewitz W., Schuster, S.

Würth KM, Reiter-Theil S, Langewitz W, Schuster S: "Getting by" in a Swiss Tertiary Hospital: the Inconspicuous Complexity of Decision-making Around Patients' Limited Language Proficiency. J Gen Intern Med. 2018 Aug 24. doi: 10.1007/s11606-018-4618-0. [Epub ahead of print]

Wuerth, K., Langewitz, W.,
Reiter-Theil, S., Schuster, S.

Kristina Würth, Wolf Langewitz, Stella Reiter-Theil, Sylvie Schuster: Their view: difficulties and challenges of patients and physicians in cross-cultural encounters and a medical ethics perspective. BMC Medical Ethics (2018) 19:70

Presentations and Posters

June 2018

"Cross-cultural topics in daily clinical encounters: ethical challenges outside ethics consultation". ICCEC 2018, June 21-23, Oxford. (Oral)

October 2014

"'Usually I forget that I am actually a migrant' said a patient..." 12th International Conference on Communication in Healthcare, Amsterdam, Netherlands, September 28th - October 1st, 2014. (Poster)

April 2014

"Any trouble with ethics? Immigrant patients' and hospital staffs' perspectives on a common cross-cultural encounter." 10th International Conference for Clinical Ethics Consultation, Paris, France, April 24-26, 2014. (Poster)

March 2014

"Kulturelle Diversität an einem Schweizer Universitätsspital aus der Innenperspektive". Careum Congress 2014 "The power of patients 3.0", Basel, March 17 - 18, 2014. (Oral)

November 2013

"Basismodul TTK: Kultur." UKBB Advanced training program for hospital staff of the University Children's Hospital of both Basel, entitled, UKBB, November 27, 2013. (Oral)

November 2012

"Diversity in Health care at the University Hospital of Basel" USB, November 11, 2012. (Oral)