

Immigrant patients in brief meetings with anaesthetist nurses - experiences from perioperative meetings in the orthopaedic setting

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ABSTRACT

Aim To explore the experience of anaesthetist nurses in brief meetings with immigrant patients in the perioperative setting.

Methods The study was conducted through open individualised interviews using open-ended questions. Eighteen anaesthetist nurses (six men and twelve women) participated in the interviews. Their age varied between 35 and 65 and they had worked as anaesthetist nurses for a period between six and twenty eight years. The text was analysed using qualitative content analysis.

Results Meetings with immigrant patients made nurses with less experience to prepare more, to study behaviour of these patients and to ask their older colleagues for advice. More experienced nurses acted on the basis of their previous experience and treated the patients in the same way as before. They also emphasised the great responsibility and wider scope of assistance needed by these patients than those born in Sweden. The majority of nurses begin the meetings with these patients by requesting an interpreter, while some nurses begin the meeting directly with the patient and, if they see it is not going well, they request an interpreter.

Conclusion Nurses need better guidelines and education in how to deal with the legislation relating to immigrant patients in order to handle the situation more effectively. Training in cross-cultural care should be improved to help nurses deal with stress through co-operation with the Migration Board and others. In order to provide for good communication and patient safety professional interpreters should be used.

Key words: anaesthetist nurses, brief meeting, experiences, immigrant patients, qualitative research

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INTRODUCTION

In the world today, we see massive migrations and we encounter people from other countries on a regular basis. People move from one culture to places that are entirely different in every way. Societies are increasingly multi-cultural (1,2). These changes strike at the roots of society including the health-care system. The provision of health care is based increasingly on a holistic, individual approach, giving each patient equal care (3-6). Entire families are included in individual care (7-10) and communication is seen as increasingly vital in the interaction between the patient, the care provider and the family (11). It is also symbolic and important in interpreting human behaviour (12). The relationship between patients and the anaesthetist nurse in the context of surgery is vital (13) and is based on conversations in which they become acquainted with one another (14,15). The foundation of this is mutual respect and empathy (13). Nurses must be trained well with the ability to help the patient feel secure and at ease, showing that they are available to the patient (16). They need to know who the patient is (17,18) and anything he or she may be worried about (17). If there is any barrier to communication, problems may arise (11). Studies have shown that language barriers, cultural differences, education and family members visiting patients (19,20) may cause difficulties and even lead to the experience of more severe pain (21) in patients suffering from cancer (22), spinal injury (23), vulvodynia (24), migraine (25), arthritis (26), non-specific chronic pain (27,28) and musculoskeletal disorders (29). However, no study has as yet been undertaken from the point of view of the anaesthetist nurses in terms of the perioperative meetings held with immigrant patients, especially in the orthopaedic setting. The nurses have a brief time to communicate with patients about their expectations and their worries and needs. In this study, we aim to bridge this gap to provide a better understanding of the interaction between nurses and patients in that setting. Person-centred care means that the person behind the patient should be seen as a person with his or her own will and own feelings and needs. Person-centred care puts the patient's perception of his/her life situation at the centre (30). The starting point should be to respect the individual patient and find ways to help him/her

to identify and explain his/her own needs. Person-centred care means that the patient should be helped to turn from being a passive party in planning nursing and medical decisions to becoming an active party in planning and decision-making (30). As the focus shifts to the patient, it can lead to increased collaboration in the meeting, improved health and an increase in the patient's sense of satisfaction. The patient's narrative about his/her illness, symptoms and impact on his/her life should be the basis for planning and performing care (30). The meeting will serve as a partnership between patients, relatives and carers. In this partnership, lifestyle, beliefs, values and health will be discussed and will be the starting point for the planning of care. In order for person-centred care to be applied, three steps should be followed (30). Step one means inviting patients to describe their experiences to show them that they are relevant and should be included in the planning or diagnosis. Step two involves sharing experiences and learning from each other by including patients in the decisions to be taken (30). Step three means creating continuity of care by documenting the patients' narratives, perceptions and the common plans that are created (30).

The aim of this study was to explore the experience of anaesthetist nurses in brief meetings with immigrant patients in the perioperative setting.

MATERIALS AND METHODS

Study design and participants

This exploratory pilot study is based on a qualitative design. It is part of an earlier study, where nurses were interviewed regarding the brief meetings they hold with immigrant patients at the orthopaedic setting. The study was conducted at the Department of Orthopaedic Surgery, Sahlgrenska University Hospital, Sweden. Anaesthetist nurses were contacted by the first author and asked voluntarily to participate in an open individualised interview. After meeting study participants, the aim of the study was presented. Nurses with at least five-year experience of orthopaedic anaesthesiology were asked to take part in the study, because those who have worked for at least five years will have had more opportunity to meet the immigrant patients. Twenty two anaesthetist nurses were recruited initially, but four were unable

to participate because of shortage of staff and for other personal reasons. An invitation letter with information about the study’s aim was sent to 22 anaesthetist nurses. As a result, 18 anaesthetist nurses (six men and twelve women) participated in the interviews. Their age varied between 35 and 65 (median 50) and they had worked as anaesthetist nurses for a period between six and 28 years (median 15 years). In order to obtain information, we performed in-depth individualised interviews.

Methods

Data were collected by the author through individual interviews, using individualised, open-ended questions, following an interview guide inspired by Kvale (31). The interviews were conducted between March and November 2017 by the first author through face-to-face interviews using open-ended questions. The interviews began with the question “Can you please describe your experience of communication in the brief meeting with immigrant patients?”. All the study participants were urged to speak freely using their own words and to respond as comprehensively as possible. The interviewer only interrupted to pose further questions or follow up on the information given by the nurses. The interviews, which were conducted on the surgical ward, lasted between 45 and 75 minutes and were audio-taped and transcribed verbatim.

Statistical analysis

A qualitative content analysis method in accordance with Graneheim and Lundman (32) was chosen for the analysis and interpretation of data. This method is capable of condensing a large amount of data into a limited number of themes, categories, subcategories and codes. The transcriptions were read carefully in order to identify the informants’ experiences and perceptions. The analysis then proceeded by extracting units consisting of one or several words, sentences or paragraphs containing aspects related to each other and addressing a specific topic in the material. Units that related to each other by virtue of their content and context were then abstracted and grouped together into a condensed unit, with a description close to the original text. The condensed text was further abstracted and labelled with a code. After that, codes that addressed si-

milar issues were grouped together, resulting in subcategories. Subcategories that focused on the same problem were merged in order to create more extensive perceptions, which addressed an obvious issue (32). According to Graneheim and Lundman, the interpretation was made primarily at a manifest level. The results were presented with direct quotes from the interviews.

RESULTS

The analysis of the text resulted in a theme and two main categories and seven subcategories based on how the anaesthetist nurses described communication with immigrant patients at the brief perioperative meeting (Table 2).

Table 1. Demographics characteristics of participants in terms of education, work and years of experience

Characteristic	Number (%) of participants
Gender	
Male	6 (33)
Female	12 (67)
Total	18 (100)
Education level	
Anesthesia nurses	11 (61)
Master’s	7 (39)
Total	18 (100)
Age	
31-40 years	7 (39)
41-50 years	5 (28)
51-60 years	4 (22)
≥ 60 years	2 (11)
Total	18 (100)
Experience	
≤ 5 years	4 (22)
6-10 years	5 (28)
11-15 years	3 (17)
16-20 years	4 (22)
≥ 20 years	2 (11)
Total	18 (100)

Table 2. Overview of categories, subcategories and theme

Category	Subcategories	Theme
Encounters with different cultures	Satisfactory meetings	Different challenges in the brief meeting with immigrant patients
	Cultural aspects of the meeting	
Challenges in the meeting	Various forms of communication in the meeting	
	Frustration in the meeting	
	Lack of time for the meeting	
	Communication	
	Patient safety	

Encounters with different cultures

In this section of the study, all the nurses stated that they prepared to meet with patients a day before. In this way, nurses were able to see which

patients they would have the following day, which made some nurses with less experience nervous and fearful. Meetings with immigrant patients caused nurses with less experience to prepare more, to study the behaviour of these patients and to ask their older colleagues for advice. More experienced nurses acted on the basis of their previous experience and treated the patients in the same way as before.

Satisfactory meetings

Most nurses in this study stated that the meetings with immigrant patients could have had different outcomes, but most meetings ended well and were mutually satisfactory for the patients and the nurses. For nurses with less experience, meetings with these patients required more preparation and study, while, for experienced nurses, this meeting was just one of many meetings. Most inexperienced nurses expressed the desire to meet as many of these patients as possible in order to learn as much as possible about them and to become more skilled in this regard, so they could give better assistance to this type of patients in future. They also emphasised the great responsibility and wider scope of assistance needed by these patients than those born in Sweden. "At the beginning of my career, I asked for only immigrant patients, so that I could learn as much as possible about working with these patients."

Meetings with immigrant patients could unfortunately also have an unpleasant ending, according to the nurses in this study. Some, both those with experience and those with less experience, pointed out the difficulties of working with those patients. "I had one patient who did not want to communicate with men at all and did not want to give me her hand because I am a man... I waited for the interpreter... it took a long time."

Cultural aspects of the meeting

Regarding the cultural aspects of this study, most nurses emphasised that, no matter how large the differences between immigrant patients are, there are also problems with the staff providing assistance to patients they know so little about. Some nurses in the study mentioned that they are also human beings, just like the staff, it is just that they were born far from Sweden and they share the same feelings, pain, suffering and everything

else as patients born in Sweden. Other nurses emphasised that precisely their lack of knowledge of those patients could lead to worry, aggression and frustration in their care providers. Most nurses in this study emphasised that cultural differences are sometimes very large in comparison with patients born in Sweden, but all the nurses in the study respected these differences when providing quality care to these patients.

"Sometimes, when I have a meeting with immigrant patients, I think that they are patients that I will never be able to care for, but they are the same as other patients and just speak a different language and have a different culture than the Swedish culture."

Various forms of communication in the meeting

The brief meetings with immigrant patients sometimes only last a few seconds, sometimes several minutes, while the meeting sometimes takes a great deal of time, depending on the waiting time and the involvement of other people in the meeting. Most nurses emphasised that there are various forms of communication with this type of patients and that, just as anaesthesia is a very varied branch of medicine, these patients also differ greatly from one another. The majority of nurses begin the meetings with these patients by requesting an interpreter, while some nurses begin the meeting directly with the patient and, if they see it is not going well, they request an interpreter. Nurses with less experience almost always consult and seek help from more experienced colleagues to ensure a successful meeting and to reduce waiting and the disruption of the surgical schedule.

"I always order an interpreter for the conversation; first, because it makes it so much easier to communicate with these patients and, secondly, because the interpreter is also a witness and guarantees my work."

"If I have a patient like this on my operating schedule, I always consult an older colleague and the meeting is always successful."

Challenges in the meeting

All the nurses identified and described two phases in meetings with immigrant patients. The first was the phase of preparation by the nurses for the meeting, before they meet the patients, and the

second phase is the direct contact with the patients. The second phase involves several challenges such as a degree of frustration, the lack of time to hold the meeting, waiting for other people who need to attend the meeting, difficulties in communicating with immigrant patients and the effect of all these components on patient safety during preparations for a surgical procedure.

Frustration in the meeting

Most nurses emphasised a certain amount of frustration that could be seen as positive or negative. Frustration in nurses can be seen in the fact that they are unable to provide the right kind of assistance to their patients, who have different expectations. In that case, most nurses align their request for assistance with the policy of the ward or clinic where they are employed. Negative forms of frustration were seen in the fact that nurses encounter problems in the meetings with patients that are caused precisely by the patients. The nurses' frustration may be caused by the fact that the patients do not agree to talk to the nurse, the patients may be mentally ill or suffer from dementia, or they do not understand the language and the interpreter is late for the meeting. All these reasons can take up precious time and disrupt the work schedule, which is not helpful for the patients or the staff.

"I thought I was prepared for the meeting and I was there with the patient... I waited 35 minutes for the interpreter... so much for my meeting."

"I once had a patient with dementia... I asked about allergies to medication and the patient asked me, 'Where is my mum?'"

Lack of time for the meeting

The time that was planned for the brief meeting with patients was often disrupted and, according to the nurses in this study, this most frequently occurred while they were waiting for the interpreter, or there may be other causes that disrupted the meeting and they had to delay the schedule. One of the main causes of lost time was that patients did not acknowledge the staff and female patients asked to communicate and hold the meeting with female staff. The nurses emphasised that, in some cases, they could recover the time by doing other work, but they most frequently wasted precious time waiting for problems to be

resolved before the operation could go ahead. Some of the nurses pointed out that they often wanted to solve the problems and not waste time, but they did not succeed.

"The patient was from an Arabic country... he did not speak a word of Swedish... I waited for the interpreter and time passed... I had no choice but to wait."

Communication

All the nurses emphasised the fact that the brief meeting with immigrant patients was almost impossible because the patients did not understand/speak Swedish. The lack of knowledge of Swedish, waiting for the interpreter, mentally ill patients, the terrible experiences the patients had been through, as well as the influence of religious and cultural factors in communication, were just some of the factors that obstructed the brief meeting with immigrant patients. Communication with these patients differed in relation to the experience and length of time the nurses had worked on the ward. Some nurses had ordered an interpreter the previous day, while others used various aids such as Google Translate, the help of relatives, other staff who spoke the same language as the patient and so on. All the nurses agreed that the best way to communicate with patients was through an interpreter. However, the nurses pointed to difficulties communicating with these patients even if interpreters were present. The difficulties could be seen in the fact that interpreters came late, they did not have enough knowledge of medical terminology, they came from the same state as the patients but were on a different side in the war in that country, which led to the patient rejecting the interpreter, female patients demanded female interpreters, or the interpreter came at the scheduled time, but the patient's operation was postponed due to an urgent case that came up in the meantime.

"We were all waiting for the interpreter because the patient demanded a female interpreter... We waited 45 minutes, but we respected the patient's request."

"To calm the patient, I gave him a 1 mg injection of dornicum... the patient asked me to explain how the drug worked, which I did, but the interpreter did not know how to translate this for the patient with complete certainty."

Patient safety

All the informants emphasised the fact that immigrant patients' safety during the brief meeting was threatened in comparison with patients born in Sweden. All the informants identified several important factors which could threaten patient safety to some extent. Lack of knowledge of Swedish, waiting for the interpreter to help, talking with patients and the interpreter in front of other patients, lack of knowledge of the patient's previous mental and physical condition and lack of knowledge of the patient's culture, religion and earlier behaviour could all cause fear and insecurity, or lead to the possibility of an error. All the informants also stated that they could suffer additional stress and make mistakes for the same reasons, regardless of whether or not the patient was born in Sweden.

"I had an interpreter beside me, everything was on time, but the patient was fearful and remained silent... time passed... this increased my stress and fear... what could I do?"

"The patient appeared to have a lot of mental and physical problems, but I could only deal with what the patient needed help with at that moment... I don't know what to say... I don't feel that I gave the patient complete assistance."

DISCUSSION

This study is the first in Sweden to investigate the relationship between anaesthetist nurses and immigrant patients in their communication during the brief perioperative meeting in the orthopaedic setting presenting the characteristics of the informants, their daily work and the difficulties experienced during the brief perioperative meeting. The results showed that many nurses worried because they lacked knowledge about other cultures and how they affect people, but that the meetings they held with immigrant patients were still rewarding. Leininger (1988) (33) pointed out that the basis for a good meeting is knowledge about the patients' different cultures. Nurses need to know about their cultural values, worldview and social structures and how these could affect the patient. Suurmond et al. (2010) (34) stated that, in transcultural care, nurses must be aware of and know about different cultures and people. The authors of the present study believe that knowledge of transcultural care

is important when meeting immigrant patients and that training in transcultural care could result in better meetings. The results showed that the informants wanted their employers to offer relevant training for working with immigrant patients, since the responsibility currently rests with anaesthetist nurses. Hanssen (2007) (35) and Hultsjö and Hjelm (2005) (36) emphasised that knowledge of other cultures is vital when it comes to understanding and meeting people from other cultures. Understanding the patient's culture and religion contributes to increased respect and care. Focusing on culture and religion, however, must not cause the patient to be seen as a representative of a culture or religion, as the patient should be viewed from an individual perspective. The authors believe, however, that applying Leininger's transcultural care theory may lead to an emphasis on the differences rather than the similarities between people, which obstructs person-centred care. Other problems faced in this brief meeting were frustration, shortage of time and communicating with immigrants who did not speak the language and needed an interpreter. In a previous study, we showed that the frustration of staff in the Swedish health-care system does not necessarily arise from immigrant patients (37). The patients may be Swedish, but, at a given moment, staff have to treat them in some way, or the patient behaves towards the staff in a way that causes a measure of frustration in the staff towards them (37). The nurses also mentioned language difficulties and problems with interpreters. In our earlier study of orthopaedic patients, we found that, for patients facing elective total hip replacement, information they receive before surgery is limited. The patients were worried about lack of information they received prior to surgery about implant choice, pain medication and anaesthesia, the lack of time they had to ask the surgeon questions and the stress involved in general (38, 19). In our earlier study of interpreters (39), we have shown that people have high expectations from consultations using interpreters, which are not always met. Interpreters are delayed, they are not professionals, or they are not acquainted with medical terminology and other problems arise when health-care staff or relatives act as interpreters. Anaesthetist nurses need to watch for and note other signs

during the course of the procedure that confirm what the patient has said. They must have an appropriate foundation for clinical assessment and decision-making, so they need information that is adequate in scope, relevance and credibility. When they have informed the patient about the course of the procedure, the patient is more included in decision-making about his/her future care. This can help relieve the patient's stress level and he/she will be more focused on the meeting and less disturbed by distractions (40). Some nurses use interpreters, but others use family members, language applications and other aids. Samarasinghe et al. (2010) (41) described how the nurses in their study believed it was not appropriate for relatives of immigrant patients to interpret for them. Relatives may find it difficult to understand and communicate the information and the responsibility is too great for them. When the symptoms are not all visible, nurses may have difficulty making an assessment and this may affect the patient in overall terms. Since the informants had different solutions to the language problem, asylum seekers and immigrants have different circumstances in their communication. When the nurses do not use interpreters, patient safety may be at risk. Johnstone and Kanitsaki (2006) (42) state that patient safety guidelines should include precise information about cultural and linguistic aspects at the clinical meeting. If this information is missing, the link between the patient's culture, language and safety may be neglected. In our study, we also found that some patients request interpreters from the same language area but also interpreters of the same gender as the patient. This may cause additional problems when ordering interpreters and result in delays to their arrival. Hultsjö and Hjelm (2005), (36) found that it was increasingly difficult to book interpreters, especially if the patients had their own requirements regarding the character of the interpreter. The results of our study also showed that nurses understand and experience the brief meeting with immigrant patients as a challenge, although for the nurses in this study it did not cause any major difficulties. In general, the brief meeting with patients was problematic precisely for the reasons given above. We believe, however, that, in addition to the reasons given above, a fundamental reason why the Swedish health-care

system is threatened with collapse is that it is in the process of a major transition, where normal nurses are easily replaced by nurses from various private firms where money is most important and they are paid for the work they do by the minute. They often combine several working days in order to earn as much as possible and they spend as little time as possible with each patient. Nurses are hired routinely, paid and, the following day, they work somewhere else in a different part of Sweden. Do we ask ourselves where the patients feature in all this, regardless of their racial, religious or other affiliation? The same thing applies to the brief meeting with patients before surgery. The purpose of the meeting is to spend time together to get to know one another, to facilitate the nurse's job and for the patient to resolve any worries or problems (43). It has been shown that nurses are better prepared to deal with the patient on the day of the operation if they have met them before (44,45). The nurse hears about the patient's worries and is therefore able to create a feeling of confidence. They help the patients to deal with their hidden, internal pain that makes them afraid, feel alone and without hope (46). It is utopian in Swedish health care today to believe that, when anaesthetist nurses meet patients the day before surgery, they can resolve all their problems in a full and comprehensive conversation. This is not possible for many reasons. There is a shortage of health-care staff, the need for health care is greater than the number of people employed, cut-backs are taking place in many areas of society, including health care, and the number of procedures undertaken is now more important than the quality and care of patients. This has resulted in the fact that these meetings often take place in a corridor or the bathroom, or that they merely serve to check the patient's identity and ask whether he/she has allergies. We wonder where this will lead and how the patients feel in all the confusion.

In conclusion, nurses expect meetings with immigrant patients to be satisfactory, but they may lead to frustration and stress, since, according to the law, the nurses are expected to provide care for patients in a way that is impossible. Nurses need better guidelines and education in how to deal with the legislation relating to immigrant patients, in order to handle the situation more effectively.

The Migration Board and others should be involved in ensuring that immigrant patients are better informed as well. This would minimise the risk of misunderstandings and improve safety. Training in cross-cultural care should be improved, to help nurses deal with stress through co-operation with the Migration Board and others. In order to pro-

vide for good communication and patient safety, professional interpreters should be used.

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