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You do not understand, out of place: A thematic analysis of interviews with foreigners on their experiences with healthcare institutions in Poznań

Nie rozumiesz, nie u siebie. Analiza tematyczna wywiadów z obcokrajowcami dotyczących ich doświadczeń z poznańskimi placówkami ochrony zdrowia

ABSTRACT

This paper presents the preliminary results of the study of foreigners' experiences with healthcare institutions in the Polish city of Poznań, as shared during 40 narrative interviews with addressed people with no or weak knowledge of Polish. The selected fragments were analysed qualitatively to determine the ways in which the participants discursively constructed their experience of regular check-ups and consultations as well as various (emergency) situations, when they sought medical advice or help but could not communicate (effectively). The analysis confirms the results obtained in the few similar studies conducted either in Poznań or in Poland in general, which point to a number of obstacles in accessing medical services on the part of these patients. The interviews feature accounts labelled as *nightmares*, *massacres* or *traumas* and include different themes. Discourse-wise, these are small stories, accompanied by emotional expressions in which they convey their feelings of helplessness, frustration and of being out of place.

Keywords: intercultural communication, healthcare, narrative interview, small story, theme

STRESZCZENIE

W niniejszym artykule zostały zaprezentowane wstępne wyniki dotyczące badania doświadczeń obcokrajowców z poznańskimi placówkami ochrony zdrowia, zebranych podczas wywiadów narracyjnych z osobami znającymi język polski w stopniu nieznacznym lub w ogóle go nieznającymi.

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Wybrane fragmenty wywiadów zostały zanalizowane w ujęciu jakościowym, w celu określenia dyskursywnej konstrukcji doświadczeń dotyczących zarówno regularnych wizyt u lekarza, jak i nagłych wypadków, kiedy to osoby te szukały porady lub pomocy medycznej i kiedy nie mogły się skomunikować (w sposób satysfakcjonujący). Badanie to potwierdza rezultaty uzyskane w nielicznych wcześniejszych podobnych badaniach, przeprowadzonych zarówno w Poznaniu, jak i ogólnie w Polsce, które zwracają uwagę na wiele utrudnień napotykanych przez tych pacjentów w korzystaniu z usług opieki zdrowotnej. W ujęciu dyskursywnym mamy tu do czynienia z małymi opowieściami (ang. *small story*) będącymi emocjonalnymi wyrazami poczucia bezradności, frustracji oraz bycia „nie u siebie".

Słowa kluczowe: komunikacja interkulturowa, ochrona zdrowia, wywiad narracyjny, mała opowieść, wątek tematyczny

1. Introduction

The current study needs to be considered in the context of major population movements and their consequences for the well-being of communities in contact, both in Europe and beyond. The National Health Fund in Poland reports that in the previous five years around 1000 people insured in other EU/EFTA (European Free Trade Association) country consulted medical institutions in Poznań, with the last three years having a comparable number of over 200 patients annually (source: National Health Fund [NFZ]: Wielkopolska Regional Branch – personal communication). This statistic does not allow for differentiation between foreigners coming to Poland for various reasons and, for instance, Polish citizens living abroad but entitled to health insurance in Poland. Nevertheless, it offers at least a rough estimate of how many of them in this particular group use these services. Some light on this matter is also shed by Głodowska (2019, p. 103), who cites the statistical data of the city, that even every thirteenth person in Poznań can be a foreigner. These people can be potentially in need of medical advice/help and, consequently, in need of an interpreter / translator. Also, according to the Statistical Office in Poznań (2021, p. 89), there were 230 immigrants coming for permanent residence in the city in 2020. As has been already observed, these people are potential patients who, if in need of medical help of various sorts, will have to communicate with medical staff. Yet, although the number of foreigners coming to Poland has been on the increase, healthcare institutions do not receive funds to cover the costs of interpreting / translating services (Głodowska, 2019, pp. 108–109, in comparison for instance to UK or USA, Michalak, 2019, pp. 123–127). If they are provided, however, it is thanks to non-governmental organisations or local authorities, for instance, due to a larger number immigrants in a given area (Koss-Goryszewska, Pawlak 2018, p. 179). Yet, regardless of their or the doctors' proficiency in any foreign language that would guarantee successful exchange of information, according to the Patient's Rights Act (2020, p. 6), every patient has the right to receive information in a comprehensible way, using various means supporting communication. In light of this fact, these people's language proficiency cannot be an obstacle in receiving medical help of any sort (see Michalak, 2019, pp. 123–127). Furthermore, the vital role of successful doctor-patient communication in the therapeutic process at all levels needs to be emphasized, both in the general understanding of its healing role or in more concrete single communicative events where particular case-related issues are discussed or information is communicated. This importance is also illustrated in the comment of one of the subjects, who decides to directly address the issue, emphasising it as a matter of "big concern".

(a) *I wanted to thank* [you] *for selecting this very sensitive topic, for me, as a foreigner, is one of my biggest concerns* (…). (S 13).[1]

[1] The fragments of the interviews with the subjects are followed by the letter S (subject) and the

2. Literature review

The current analysis is intended to contribute to the relatively small body of similar studies conducted in Poznań (Mińkowska, 2010; Luck *et al.*, 2019) and in Poland in general (Wąsikiewicz-Firlej *et al.*, 2022), which, generally, point to a number of obstacles in accessing medical services by foreign patients in the city and in Poland. A relatively large study carried out by Wąsikiewicz-Firlej *et al.* (2022) featured 53 semi-formal narrative interviews conducted between May and June 2018 and 2019. Subject-wise, their aim was to elicit subjects' perceptions regarding cultural sensitivity / awareness as well as foreign language fluency in their overall well-being when living abroad. The respondents were between 18 and 30 years of age and had experience of international exchange in Poland. The results show that 23 interviewed people declared that they experienced communicative problems with medical personnel, 24 people denied any problems, six people did not mention these problems at all. Wąsikiewicz-Firlej (2022) refers specifically to the Migrant Integration Policy Index report (MIPEX, 2015, 2020), which was commissioned to assess the extent of governments' engagement in promotion migrant integration in the EU member states and some other countries. The document includes 167 points to be considered and focuses on: "labour market, family formation, education, health, political participation, right to permanent residence, right to obtain citizenship and protection from discrimination" (Wąsikiewicz-Firlej 2022, p. 121). According to the report, health services and policies in Poland were labelled by the subjects as slightly unfavourable (score: 27), "generat[ing] obstacles to migrants and (…) not respond[ing] to their specific needs" (Wąsikiewicz-Firlej 2022, p. 122). The primary problem is both the access to services as well as the available information on them. However, the report also marks a significant improvement in comparison with the previous ranking (MIPEX, 2015). In this context, an example is given of a website dedicated to health-related information including education, promotion and, in general, orientation (Wąsikiewicz-Firlej, 2022, p. 122). In another study, the quality of healthcare services in Poland as used by Ukrainian citizens was examined (Luck *et al.*, 2019). The results were obtained via survey administered in person and online. They demonstrated a lack of information about the system, which also resulted in the lack of chosen GP upon respondents' arrival, which, for instance, was not the result of their poor knowledge of Polish. The authors forward an argument for making the information about the Polish healthcare system more available, which was also an argument of the majority of the studied foreign visitors. Similarly, Mińkowska (2010) points to a language barrier and overall lack of information about the treatment of foreign patients within the healthcare system in Poland as the main obstacles in receiving medical assistance (the latter problem was also reported on by migrants in Ireland by Migge and Gilmartin (2011, p. 1145), and whose comments appear to almost mirror the ones elicited in this study – see section 4 below). Many observations of Mińkowska's respondents have also been shared by the participants of the current study, e.g., problems with communication with the frontline staff, lack of information in foreign languages, including printed forms, and, as a result, reluctance to use the services[2, 3]. Finally, a relevant conference should be noted, *Kulturowe uwarunkowania opieki nad pacjentem* [Cultural

number of the interviewee. All quotes are provided in their original form.

[2] On the other hand, the ones stemming from lack of relevant specialised vocabulary were mentioned by Lee *et al.* (2010, p. 112) in their study of Korean immigrants in New Zealand.

[3] It needs to be added that Mińkowska's work reports on the results obtained in a larger project "Bariery i czynniki sprzyjające integracji obywateli państw trzecich na rynku pracy, w służbie zdrowia oraz edukacji. Antropologiczne studium przypadku miasta Poznania" [Factors Assisting and Restricting the Integration of Third Country Nationals into the Labour Market, the Health Service and Education: An Anthropological Case Study of the City of Poznań], conducted by Centre for Migration Studies at Adam Mickiewicz University in Poznań and co-funded by the European Fund for the Integration of Third Country Nationals (EFI).

conditioning of patient care] organised by Poznań University of Medical Sciences and Poznań City Council, which took place on 26th February 2020 in Poznań. The conference featured a variety of presentations devoted to healthcare delivered to foreigners which mirrored the articles in a publication under the same title (Głodowska *et al.*, 2019), also presented at the conference.

The overall conclusion of this review of the literature on the topic can be summarised by Koss-Goryszewska and Pawlak's (2018, p. 178) observation that this particular sphere of foreigners' integration still requires considerable research attention.

3. Aims, subjects and methods

The data for this study was 40 narrative interviews (Flick, 1998, 2000; Jovchelovitch, Bauer, 2000) conducted[4] between November 2020 – September 2021 with people who lived or used to live Poznań, with no or weak knowledge of Polish. These people were between 20 and 50 years old (with one exception of an elderly person). Respondents generally either had a university degree or were students. The procedure of recruitment of the participants included the following steps. First, particular institutions / businesses were contacted in order to access the potential target group. These were Polish Cafe (a school of Polish which also organises monthly meetings for foreigners who wish to talk to native speakers of Polish), International Poznań community (an online community bringing together locals and foreigners in the city), Migrant Information Point (a local non-governmental organisation offering information and help for foreigners in Poznań) and Poznań City Hall. Not all of these organisations ultimately offered help. The admins of several groups on Facebook where foreigners discussed various matters related to their everyday life here, were also contacted. Whenever a willing participant was encountered, the snowball technique (Manohar *et al.*, 2019, p. 85) was used, which was helpful in the recruitment of further participants. Very often, the recruited subjects recommended participation in the study to their friends. Ultimately, 40 people of various nationalities – British, Belgian, Hindu, Nigerian, Turkish, Spanish, Brazilian, Iranian, etc. agreed to participate. Upon their acceptance of the invitation an email message was sent, introducing the researcher's workplace and study aims in general, which read:

I would love to listen about your experience with healthcare institutions in Poznań. In detail, if you had to seek medical help, how were you received, did you have any communication problems, were interpreting/translation services provided, did you feel you were understood and taken care of?

If the person agreed, another message was sent with an informed consent document detailing information about the study. If it was signed, meetings via Teams / Zoom / WhatsApp or later in person were arranged, which were recorded. The selected fragments were then transcribed and analysed qualitatively in order "to investigate complexities of our social world" at the expense of "measuring, counting and prediction" (Tuffour, 2017, p. 12; see also Finlay, 2011). This helped to determine the ways in which the participants discursively constructed their experience of regular check-ups and consultations as well as various (emergency) situations when they sought medical advice or help but could not communicate (effectively). These situations included basic medical services, vaccination, emergency cases as well as hospitalisations. Additionally, the sample of patient participants was complemented with a small sample of six representatives of the medical staff, including the head of a hospital, a physician, a head of a hospital emergency department, paramedic co-ordinator, a departmental nurse (of a casualty department) and a medical secretary, the majority of which specifically dealing with foreign patients. Their contribution was meant to offer the perspective of the other side involved in medical care.

Consequently, a narrative discourse approach was adopted, understood as "tak[ing] as its object of investigation the story itself"

[4] This data collection technique was applied by Lee *et al.* (2010) in their study of Korean immigrants in New Zealand and by Migge and Gilmartin in their study of immigrants in Ireland (2011).

(Riessman, 2000). It may be seen as "a family of approaches to diverse kinds of texts, which have in common a storied form" (Riessman, 2003, p. 1). However, the stories analysed were elicited via interviews, therefore a narrative method of inquiry was adopted, as opposed to using data available prior to the study. According to Robert and Shenhav (2014, p. 2), narrative is "the very fabric of human existence". In the context of the current paper, the narrative is seen as an individual's account of some events by means of which the respondents refer to and evaluate a chosen aspect of their life and how they cope in various circumstances. Consequently, the transcripts were scrutinised for stories, both big and small, i.e., those which, according to Labov and Waletzky (1967), tend to be monologic, very often researcher-generated and following canonical structure, or by contrast, ones that, according to Bamberg and Georgakopoulou (2008), do not necessarily contain all their canonical elements, are incomplete and spontaneously elicited, and thus seen "as momentary and fleeting shifts into narrativity". With reference to these distinctions, summarised also by Baynham (2011, p. 47), the stories analysed were to some extent researcher-generated, however they were not monologues and often appeared spontaneously as recalled by the subjects. Additionally, the stories were searched for recurring themes (Riessman, 2003; Braun, Clarke, 2013) where a theme is defined by Braun and Clarke (2006, p. 82) as an element that "represents some level of patterned response or meaning within the data set". Consequently, with reference to the multifaceted nature of stories, the current analysis of identified accounts rather taps into their thematic character and not to the structure or chronology. This is because the themes identified helped to structure the material collected but also were the points around which the interlocutors organised their accounts.

As will be shown, thematically, in the interviews, the participants identified problems, offered their personal take on the situation reported, and enumerated coping strategies and suggestions for improvement. The experience of the apparent problems which are yet to be solved by healthcare institutions provides an insight into the way in which they talk about these apparently sensitive issues which concern their well-being and feeling of safety.

In the following section the results are divided into the themes touched upon by the respondents and then discussed and illustrated with relevant fragments of the interviews.

4. Results and discussion

4.1. Identifying problems

4.1.1. Information barrier

On the basis of the interviews conducted, what appears to be even a greater problem than the inability to communicate is the information barrier. In general, this can be defined as a lack of information when in need of medical help. In detail, it can pertain to any encounter with the system before, during or after, in which the patient is not sufficiently informed about the service or any other aspect related to the functioning of healthcare institutions (see also Koss-Goryszewska, Pawlak, 2018, p. 179). This was mentioned both in relation to emergency situations when some respondents needed help immediately, but also in routine health-seeking behaviours when patients simply did not know where to go or what to do in order to get something done. One of the interviewees aptly describes this problem as:

(b) *An absolute mystery which hospital you should go to* (…) *an esoteric system*. (S 1)[5]
(c) *My department had never told me and still I'm not totally clear about this, what to do actually, how to use this public insurance that I'm paying a lot of money into*. (S 16)[6]

In (c) above the interviewee refers specifically to the public insurance scheme and the fact that although he has been working for three years

[5] "I am lost, really I am lost, I just don't know how it works" (Migge, Gilmartin, 2011, p. 1145).

[6] "I have some kind of health insurance from work but I am not even sure what it covers. I know if anything goes wrong while I am at work I am covered ok but it is when I am not at work" (*ibidem*).

now, he still does not know how it works, but he is nevertheless definitely aware of the financial burden it has on his remuneration, which he directly points to. It is worth noting that almost the same comments were given by migrants in Ireland in Migge and Gilmartin's (2011, p. 1145) study (see quotes in the footnotes).

4.1.2. Communication barrier

The second most widely reported problem, and, apparently, the most expected one, is the communication barrier. However, the particular group mentioned by the respondents with whom conversations are the most problematic, are not doctors themselves but rather the frontline staff who do not speak English. This translated not only into difficulties when paperwork needs to be completed before the patient receives help, as in case of an emergency, but also, for instance, when arranging a regular check-up at a family doctor's (*cf.* Mińkowska, 2010, p. 157).

(d) *I have had many issues* (…) *when I called various physicists and asked them if the person spoke English, they usually said like 'słabo'* (…) *and they are hanging up* (…) *that is one issue that I still cringe at* (…) *when somebody just hangs up on me*. (S 10)

What can be gleaned from this statement is that the apparent inability to communicate may result not only from lack of linguistic competence on the part of the frontline staff (which in fact cannot be verified entirely in a communicative encounter) but also from mere reluctance to communicate in any way when faced with a foreigner, as mentioned by S 37 below (see also Mińkowska, 2010, p. 158). Consequently, in a telephone conversation, a foreigner may be faced with being hung up on. The situation was also summarised by another speaker with these words:

(e) *The secretaries in hospitals are not very nice people*. (S 37)

Some other speakers, who points to this problem too, stress however, that it is precisely a foreign language that makes the situation more difficult to bear.

(f) *UK has as many grumpy and unhelpful staff as in Poland, but the difference is that they are grumpy in English*. (S 1)

(g) (…) *my vocabulary in Polish wouldn't reach that far* (…) *when it came to more complicated stuff* (…) *or something more involved* (…) *it was either explained to me in English by the doctor* (…)*then I would have just called my wife*. (S 19)

As a follow-up to that, in some cases, it is not the personnel who do not know the language, but the fact that the health-related problems with which foreign patients present, may be complex in nature and even their command of Polish, if any, may not be enough due to lack of specialised vocabulary (which was also mentioned by Lee *et al.* (2010, p. 112) in their study of Korean immigrants in New Zealand). In the above-given case (g), the subject was lucky enough to encounter a doctor who was able to explain things in English as well. Still, the command of English as represented by the Polish healthcare staff in general is evaluated poorly.

(h) *The communication in English is awful*. (S 13)

Furthermore, a number of them mentioned that the doctors' command of English is only in theory, which was reported when describing visits in the private sector, where, before actually arranging a meeting, patients can view doctors' professional profiles online and be informed, among many other things, whether the person speaks English. This option was particularly appreciated by the respondents and mentioned by them as the most important reason for resorting to the private healthcare sector. However, the information provided there was not always reliable. One of the interviewees describes their experience with doing lab tests in the private sector.

(i) *For the next test I called and I asked specifically that I needed someone who speaks English, so I went there and again, again, no English*. (S 26)

A few speakers pointed to another very important aspect of their life in Poland. Being a foreigner may often require from them to go to an institution or arrange a meeting, and upon

registration, it may turn out that forms, e.g., to make a complaint (see example (j) below), and even ticket machines (see example (k) below), offer instruction only in Polish.

(j) *I received a survey* (…) *but you know, it is also difficult to complain, it's the same, you know, you have to do it in Polish, when you want to complain, you do not receive help to make a complaint*. (S 26)
(k) *This is extremely difficult, even all the machines you need to make an appointment, your number, it is not in English, it is a challenge, even the forms* (…) *you need to ask everybody how to do it, you need to spend time and energy, it should be a little bit easier*. (S 11)

The case with the patient wanting to make a complaint (example (j)), actually because of being yelled at by the doctor, who felt unhappy about having to speak English, as he himself admitted (see also example (r) below), according to the patient, seems particularly critical, since it is the patient's right to report any unprofessional/unethical behaviour in this particularly sensitive context, and, consequently, such an option should be available to them, regardless of what language they speak.

As a result of being frequently disaffected by the way matters are handled in healthcare institutions, many of them feel discouraged to do anything unless it is really necessary (compare Al Shamsi *et al.*, 2020):

(l) *Probably eventually I would have to go to hospital for that* (…) *I have been kind of delaying that*. (S 10)
(m) *There was a time I was very bad in the corona time and if I would be in Turkey, I would definitely call, but I didn't call, because if I would call, they wouldn't understand me probably, so it would change nothing, so I didn't call*. (S 11)

It may also mean generating extra costs as being faced with the already mentioned quality of service in the public healthcare sector, foreign patients often resort to private options. Last but not least, such situations may result in the feeling of helplessness at least or in particularly dramatic situations, which will be presented in the next subsection.

4.2. Patients' take on the events reported

As has been already alluded to, the respondents shared a number of stories, some particularly dramatic, which not only provide instances of particular problems, but, more importantly, their personal take on the events reported.

One of the themes that appeared in the very first interview and then reappeared was the event the birth of child. It was shared by two fathers and later by a mother. These circumstances were particularly difficult for the fathers who accompanied their partners / wives and, as reported by them, were left to themselves in the waiting rooms or corridors without any snippet of information for long hours.

In the first story told, the interviewee not only reports on being left alone without any updates on his wife's and child's condition but also emphasises how the attitude of the staff, communicated *via* gestures and words, made him feel unwelcome. It is particularly visible through the use of words referring to passing time and their repetition – "minutes", "another nurse", "another minutes", but also labelling the staff behaviour as being "annoyed" as well as his feelings of being "tired", "stressed" and "unwelcome".

(n) *I am left there, me and my bags, nurses, the nurses weren't very nice at all, 2 o'clock in the morning, I was very tired, very stressed out, no idea what was going on, she kind of speaks to me,* (…) *I've no idea what you are saying to me,* (…) *she was annoyed*.
(o) *She just assumed I did not speak Polish, I was just sitting there* (…) *for 40 mins, and another nurse came along to take me outside the room, and pointed to a chair, I stayed there for another 40 mins, it seemed to go on forever, it gave the impression that I wasn't welcome*. (S 1)
(p) *they were so crossed about the fact you do not understand, out of place, we do not want you to be here, thank you very much, you make our job more difficult*. (S 1)

The last aspect is reminiscent of one of the problems foreigners faces in the Polish healthcare

system – apparent reluctance on the part of the personnel when faced with patients not being able to communicate in Polish. This story is also the first example of the group of accounts that were specifically labelled by the subjects – the one at hand – a *horror* story.

In another example, an account is given of a similar situation when the patient faces annoyance, but this time also rudeness and brutality the moment he appeared at the surgery.

(q) (…) *as if I was disturbing her just before she was ending her shift or something. She only spoke Polish to me. Fair enough. But then she was incredibly rude and brutal*. (S 14)

In yet another example, a situation is described when the patient starts speaking English. They are met with yelling from the doctor, which is described in detail. The patient refers specifically to how it felt and what they wished they had done, but instead how they rationalised the situation favouring the end justifying the means.

(r) *You can wait, we have someone who speaks English* (…) *and I got into the doctor's office and I started "Good morning…" and everything in English* (…) *this was the doctor that started to yell to say that he hated to speak English, that he knew how to speak English, but he hated to do it and he started to yell and to say umm to curse in Polish which I understand in my basic Polish* (…) *and he was really, really upset* (…) *I stayed at the office, I kind of wanted to go, but in the end I stayed. I thought he can speak English, so he has to get his work done*. (S 26)

The next example also confirms the difficulties with finding personnel who speak English. Additionally, here, similarly to Speaker 1, Speaker 11 labels the situation in Polish as 'masakra' ('massacre', which appears to be making this special effect if said in Polish by the speaker). Secondly, the word 'again' emphasises the continual character of the problem, as previously observed. The speaker also openly reflects on her losing faith in the Polish system, something that appears to be relatively isolated in the collected material.

(s) *And again there was like nobody* [in the hospital] *speaking English, it was a little horrifying for me* (…) *it was really horrible and at that moment, it broke my like good feeling about Polish healthcare, 'masakra'*. (S 11)

Finally, an example of a similar event that could be labelled as an odyssey in search of English speaking personnel. A person whose pregnancy was managed privately had to see a diabetes specialist and was referred by her doctor to what seemed to him an institution in which she would find no trouble communicating in English. This turned out, however, to be an odyssey which lasted a few hours and left her completely exhausted.

(t) *They referred me to* [institution name] *to see specialist* (…) *he* [the doctor] *saw* [institution name] *as the only place the doctors and nurses might speak English, I was actually really anxious to go and finally I got an appointment from a friend, because calling there and making appointment in English was a difficult thing, so my friend called them and took an appointment for me.* (…)
(u) (…) *I asked people, then was one lady who took me to a student who was speaking English she took my phone and read it* (…) *again there was nobody who speaks English, so I had to use Google Translate I did a lot of back and forth* (…) *then I had to wait for another hour* (…) *the token number, they also call that in Polish* (…) *I was so tired that at the end of that I had my blood pressure shoot up* (…). (S 23)

The most dramatic situation was offered by an interviewee who experienced particularly stressful events. The person confessed that due to these initial experiences they dreaded the thought of any further encounters, which was exacerbated later by the pandemic situation.

(v) *Imagine that moment when I arrive at the medical centre, I had a high fever, my body was shivering, and, you know, I was in a very devastated situation, my health condition was not good and at the same time you have to focus and concentrate how you are going to communicate with these people, it was a very challenging task, how to convey, put the message across, find a channel, a proper channel for communication*. (S 13)

In this account, one can notice two distinctive features. First, it is a highly emotional discourse of both physical and mental suffering, exemplified by such phrases as "body shivering" and "devastated condition" respectively, which is confronted with the situation, where the patient cannot, however, concentrate on the condition and must struggle to communicate in the environment which they dread to function.

(w) *A few months ago, at 4 o'clock in the morning she* [wife] *woke up and told me I had severe pain in my stomach, she was shouting, it was very painful and I was so confused what to do, so based on previous experience I didn't call 991, because I knew* (…) *they're not gonna send me any help* (…) *even those receptionists, they couldn't understand us, my wife was in pain, just shouting, she couldn't even walk, they just asked us to sit, they couldn't understand what is the problem, waited for more than half an hour, my wife, she was crying, it was such a tragic experience to see someone, loved one in pain, her eyes were full of tears* (…) *nightmare, trauma*. (S 13)

The situation becomes even more dramatic, when the suffering which was experienced by the husband becomes the suffering of the beloved wife – expressed through such words as "pain", "shouting", "crying", but the circumstances remain the same, and so too does the helplessness in that situation.

The same helplessness is expressed in the context of the outbreak of the coronavirus, as it is viewed as something even more likely to worsen the already dramatic circumstances one has to face when in need of medical help.

(x) *And when I heard about COVID in Poland, I was so concerned, because here one of my biggest concerns is being exposed to hospitals and medical centres* (…) *I was so scared, I'm still now* (…)*, you know, if I am sick, what should I do?* (S 13)

Another group of comments concentrated not so much on the descriptions of problems where language was an issue but instead pointed openly to it as an issue of concern. Speaker 26, who experienced rudeness and brutality on the part of the doctor, openly admits that it would be possible for them to use Polish, but if there is a possibility not to, it is more relaxing without this trouble, which points to the importance given by this person to some form of comfort the patient may expect in such a situation.

(y) *I could have coped in Polish* (…) *but it is always nice when you don't have to, when you're stressed, in a very difficult situation, you prefer to be able to just relax and communicate without having to sort of translate things in your head*. (S 14)

Such a direct comment was also offered by a subject whose wife had had a stroke and had to stay in hospital. Soon he was informed that she was not recovering since she could not communicate with anybody. Consequently, he was offered a possibility to leave her a phone, something which should have been offered upon her admission.

(z) (…) [in hospital] *they told me I had to go home, but she had to stay, so my wife was in a hospital, unable to communicate with anybody, unable to communicate with me, because they would have no visitors and within a couple of days one of the nurses called me, who spoke a little English and said your wife is not doing well, because she is angry, because she can't talk to anybody and tell them what's wrong. So I manage to set up taking them a telephone* (…). (S 24)

In example (z) above and (aa) below, the author, unlike in the previous ones, focuses not so much on the very language but rather on the sheer amount of information or rather lack of it, regarding the condition of the partner. In detail, the information was not passed on to them, automatically in a way, but rather had to be sought for.

(aa) *While in hospital* (…) *the actual service was good* (…) *it was very smooth and I don't think I was treated badly, I don't think I was treated well, but I wasn't treated badly* (…) *what I lacked was the communication side of things, the medical decisions were presented to me as a fait accompli, getting information was difficult, I think*. (S 4)

The final group of comments are those in which the subjects directly express their appreciation of

the very study, in that it allowed them to share experiences and, this way letting their voices be heard. In the two quotes provided, the subjects bring up the vouchers that were offered as a bonus for participation in the study at hand and which they declare they do not need since, according to them, it was the sharing experience that made them participate, regardless of any gratification provided.

(bb) *Even if there will be nothing* (…) *because I think this research, I want to thank you, because it means you think about this, so this means you care and you invest your work and energy in it*. (S 11)

4.3. Coping strategies

Finally, in light of all the reported problems, the subjects admitted that they had devised various coping strategies. The first one was bringing a spouse / someone else with them (see also Mińkowska, 2010, p. 158; Migge, Gilmartin, 2011, p. 1146 – in the case of migrants in Ireland). One of the interviewees confessed that

(cc) (…) *when he* [my husband] *is not at home, it is hard for me to do anything related to my health*. (S 20)

Another interviewee admitted that every healthcare consultation is arranged by his wife and it is not only because she is a doctor herself and it is easier to get things done this way institution-wise, but also because he cannot speak Polish and this appears to be the greatest difficulty. On the rare occasions when he had to deal on his own – getting vaccinated or having an occupational health check-up – all these instances were problematic (S 37).

Another strategy that is used widely among the interviewees is the phone application Google Translate. The common mention of its use by the interviewees paints a picture of foreign patients relying on their mobile phones all the time, whenever visiting healthcare institutions.

Another common practice is writing things down, e.g., drug names to be prescribed, and delivering it to the reception in order to avoid direct contact with the frontline staff dealing with registration, personal data collection and documentation, etc. A similar practice has already been mentioned by the subjects with bad experiences with arranging meetings or obtaining information via telephone, which they later consciously avoided. However, while in the latter case, the consequences of such practices might be dire, as this essentially means avoiding medical consultations and possibly refraining from treatment, in the former case, the outcomes might not be that dire, yet they may prove to be a source of inconvenience. In such cases, gesture use may be an undeniably useful addition to often unsuccessful verbal communication.

Lastly, as has already been stated, frequent unsuccessful and ultimately frustrating experiences with healthcare institutions – be it encounters with doctors lacking English skills or the inability to find them, as well as the unsuccessful encounters with the frontline staff – may lead to the decision on the part of the interviewees to move to the private sector, which means generating additional costs.

However, in the interviews conducted with medical staff, in general, the widely held opinion is that they go to great lengths in order to communicate with foreigners. As a departmental nurse said:

(dd) (…) *and we communicate in different ways by means of a translator app* (…) *we ask someone from the ward who has some knowledge of the language and they sometimes help, sometimes by means of gestures* (…) *I also created a survey in English which patients read and choose the most important symptoms* (…) *and this serves as some form of an interview* (…) *we need to manage somehow, that is our duty*. (S 43)

By stating that it is "their duty", she explains in a way that this dealing at all costs is a must. She also mentions that many of them are not young and this means that they may not know English, which was not taught in schools before 1990 in Poland.

(ee) (…) *so far, I have never had a situation in which due to cultural / language difficulties I was unable to help the patient. Always, with the help of others, either with my help or with the help of*

other doctors, this help is always provided. We always manage somehow. (S 41)

In general, while the various representatives of medical staff primarily admitted that they try to deal with such communicative crises, and though it is not always easy, they somehow manage, as in (dd) and (ee) above, in the patients' eyes, these encounters are rarely successful. However, the disproportion between the numbers of interviewed patients and medical staff does not allow for such conclusions to be valid.

4.4. Suggestions for improvement

Finally, at the end of each interview, the subjects were asked to offer suggestions for improvement, referring either to their own experiences, or in general.

Generally speaking, a number of participants mentioned that a roadmap for incoming visitors should be created, in which they could find information where to go and what to do, healthcare-wise, not only in case of an emergency. They also emphasised that the language must be English, which may suggest that they had had previous experiences with similar material, but possibly in Polish.

One of the interviewees illustrates this need in an apt comment resorting to an academic metaphor:

(ff) *Orientation is a fail, for foreigners* (…) *I think it's unethical, you could challenge it, it's almost illegal. If healthcare is a guarantee, communicating healthcare must be a guarantee as well. It is a burden, I understand that, but it's an inherited burden. They must make the orientation clear outside of the Polish language, for those who need it*. (S 17)

Other speakers also mentioned that an Infoline would be useful, where they would be able to receive information regarding the healthcare facilities and services in the city. What all the participants agreed on is that the frontline staff must know conversational English and this conclusion seems to have been formulated on the basis of their direct and unsuccessful encounters when they were unable to arrange a consultation, receive information or, in extreme cases, even being hung up on (see (d) above). One of the interviewees also mentioned that multilingual documentation should be available, such as the one patient have to fill in upon admission to hospital or simple registering at a doctor's practice. In this context, it is worth mentioning the case described when one of the interviewees wanted to make a complaint but the document was in Polish (see example (j) above), or multiple cases when the subjects had their COVID vaccination shots and the documents to be filled in before the administration were in Polish too. However, in this particular case, there were also instances when foreign students reported that they had received the document with English translations.

5. Conclusion and closing remarks

In this qualitatively oriented analysis of the transcripts of the interviews with foreigners about their experiences with healthcare institutions in Poznań, the following themes have been determined: identified problems, their personal take on the situation reported, enumerating coping strategies and suggestions for improvement. The themes occurred in small, primarily non-canonical stories, recalled spontaneously in the discussions about the healthcare institutions. The stories concerned healthcare encounters of various sorts with which the subjects were primarily dissatisfied with. The dissatisfaction resulted in the feeling of helplessness, frustration and of being out of place, which was discursively constructed by means of emotional language and expressions conveying the recurring character of the problems. The former may be illustrated by such words as "horrifying" (example (s)), including the group of words directly referring to the feelings of being "tired" and "stressed" (example (n)), "out of place" (example (p)), "scared" or "concerned" (example (x)) on the part of the interviewees. Regarding the latter, labels the subjects attached to the stories included "masakra" ("massacre", see example (s)) or "horror story", or words such as "again" (example (i)) or "another" (see example (o)). The respondents were also relatively direct in their expressions of both anxieties and fears regarding healthcare, but also their evaluations of the healthcare system in Poznań, e.g. "I think" (example (ff)).

Poznań is a city that officially prides itself on being open to incoming visitors, inviting business people, students and tourists alike. Many interviewees emphasised that they love Poznań and the people here, and that it is just the aspect of healthcare services that is problematic. Furthermore, even when they say they are satisfied overall with the care they receive here, they admit that it is only so because they rely on somebody else's help. Discourse-wise, the interviewees shared small stories (Bamberg, Georgakopoulou, 2008) of primarily unsuccessful visits and consultations, accompanied by emotional expressions in which they convey their feelings of helplessness, frustration and of being out of place. What may serve as a final conclusion for the article was offered by one participant as a reaction to an observation that one of the hospital heads in Poznań had made. When asked how they usually proceed whenever they are visited by a foreign patient, the hospital head openly admitted that they always hope things would work out somehow. And this is how the interviewee replied to that:

(gg) *Things do not work out. They should count on the fact that they are not going to work out and work from that as a basis for improving*. (S 24)

At the same time, as has been observed in the interviews with the medical personnel, healthcare staff declare themselves to be doing everything they can to streamline communication between doctors and patients (example (dd) and (ee)) and generally do not complain much about their communication with foreign patients.

Concluding, bearing in mind the already established fact that good doctor-patient communication is key to successful therapy but also to patient satisfaction with healthcare, the author subscribes to all the suggestions for improvement proposed by the respondents, whilst at the same time stressing the fact the patient's right to information is guaranteed by the state but also pointing to the uniqueness of this particularly sensitive context concerning patient well-being. It seems that there is no better confirmation of such a conviction coming from a patient that when upon arriving at a hospital and hearing somebody from the staff speaking English, they raise their hands in triumph (S 41).

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