



“What it really takes” – A qualitative study of how professionals coproduce healthcare service with immigrant patients



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ABSTRACT

Background: The concept of coproduction shows great promise for meaningful partnerships between patients and health professionals. This is particularly relevant for immigrant patients who are less inclined to take an active role in consultations. The present study described health professionals' practices and experiences of coproducing healthcare service with immigrant and refugee patients in clinical encounters.

Methods: We conducted a three-phase qualitative study with immigrant and refugee patients and health professionals at an interdisciplinary outpatient clinic for immigrants and refugees with complex long-standing health problems at a Danish university hospital. First, we conducted 25 observations of consultations between seven professionals (three doctors, three nurses, one social worker) and 24 patients with varied backgrounds and health problems. Findings were discussed in a focus group and individual interviews with the migrant clinic's staff. Finally, the themes were discussed with co-researchers and revised in a member check with experienced clinicians. Data were analyzed through meaning condensation, supported by the NVivo software.

Results: We identified four themes characterizing the work of health professionals in creating coproduced healthcare service: a team effort of sense-making, disentangling the chaos first, when everything fails - listen to the patient, and continuity - becoming part of the patient's story.

Conclusion: Interdisciplinary work fostering values of doing what makes sense to form a positive partnership with the patient allows health professionals to act autonomously, flexibly, and creatively. Using communication tools designed around patient needs, create optimal conditions for coproduction as health professionals empathically validate and integrate patient experiences. Professionals need advanced listening and relational skills and tolerance of ambiguity and insecurity. Relational continuity facilitates long-term coproduction but also bears risks of emotional dependency.

1. Introduction

The concept of coproduction has the potential to improve healthcare service through meaningful and genuine partnerships between patients and health professionals (Batalden et al., 2015). Its premise is that any public service is inevitably coproduced by two parties (Osborne et al., 2016). On an individual level, this is especially important for immigrants and refugees in the role of patients, who have limited opportunities to access and to be involved in their healthcare (Brämberg et al., 2010). Even in countries such as Denmark, which in its healthcare

system strongly focuses on equality in healthcare (Danish Ministry of Health, 2019), immigrants face inequity in health and access to healthcare compared with the majority population (Folmann Hempler et al., 2020). Established one-size-fits-all approaches for patient participation are less beneficial for immigrant patients. They are less inclined or willing to take an active role in consultations and less likely to have their involvement supported by the health professional (Street et al., 2005). Hence, immigrant patients are at risk of receiving lower-quality care and having worse health outcomes due to inequalities in the utilization of healthcare services caused by insufficient language proficiency and knowledge on how to use the healthcare system (Brämberg et al., 2010). Introducing coproduction principles has the potential to address inequity in service delivery, while at the same time improving outcomes, especially for vulnerable and marginalized patients

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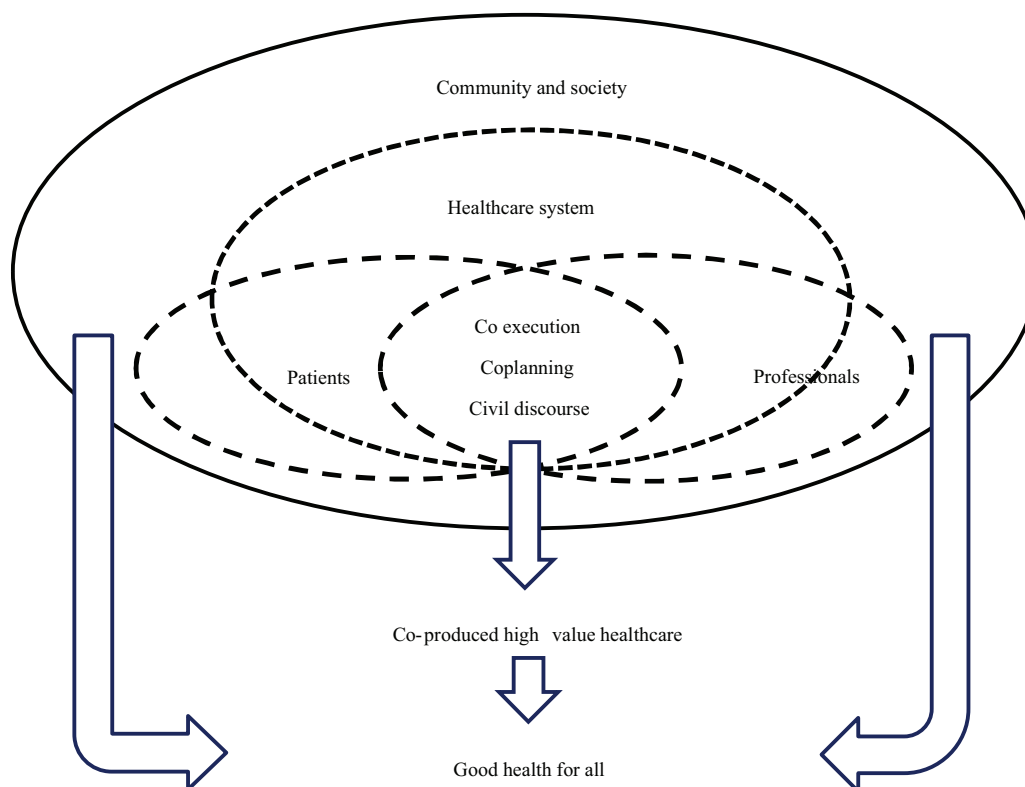


Fig. 1. Conceptual model of healthcare service coproduction (Batalden et al., 2015).

(Baim-Lance et al., 2019; Jakobsen and Andersen, 2013; Bosco et al., 2019). They need effective communication that allows for involvement in decisions and actions to the degree they can and desire (Park, 2020).

Batalden and colleagues' conceptual model for healthcare coproduction (Batalden et al., 2015) (Fig. 1) complemented with Elwyn and colleagues' coproduction cycle (Elwyn et al., 2019), provide a clear and informative view of how coproduction is working in a clinical setting: (1) Good service coproduction requires a respectful civil discourse with trusting and effective communication to understand the patient's world and their lived experience, thereby *co-assessing* the individual's health status, health concerns, and health goals in the context of their overall well-being and quality of life; (2) *Co-planning* a treatment plan that fits a patient's goals, context, and capabilities invites a deeper understanding of one another's expertise, resources, and values; and 3) *Co-execution* considers a patient's capabilities and demands shared goals, mutual trust and responsibility, and accountability for performance. These relationships and actions are supported and constrained by the structures of the healthcare system as well as by other forces or services in the wider community (Batalden et al., 2015).

Effective coproduction on the individual level can strengthen resilience and autonomy by enabling patients to manage current health problems and reduce the likelihood of future problems (Elwyn et al., 2019). Yet, practical knowledge about how immigrant and refugee patients can use their own experience and expertise to participate in decision-making and the coproduction of health is scarce (Park, 2020; Dobler et al., 2017). Recently, we summarized facilitators for coproduction showing that immigrant patients can be a valuable source of information and powerful coproducers of their health if the healthcare organization and front-line health professionals prepare for it (Radl-Karimi et al., 2020). However, how to create valuable coproductive interactions in practice remains elusive (Hardyman et al., 2015). The aim of this study was to describe the actual work of coproducing healthcare service with immigrant and refugee patients from the professional perspective.

2. Methods

2.1. Setting

The study setting was an interdisciplinary outpatient clinic for immigrants and refugees at a Danish public university hospital. The team, consisting of seven nurses, four doctors, and two social workers, provides hospital-based coordinated care for immigrant and refugee patients with long-lasting, complex, and unexplained symptoms (Sodemann et al., 2013). A typical course at the clinic starts with reviewing of a patient's referral, creating an overview of a patient's health and life situation, formulating a shared action plan with agreed roles and responsibilities. Further, the coordinated care includes resuming missing examinations, completing insufficient diagnoses, and coordinating network meetings with necessary stakeholders from the health and/or social sector (Sodemann, 2019). Consultations at the clinic usually last around one hour, which is unique compared to most other places in the healthcare sector (Danish Ministry of Health, 2011). Trained medical interpreters are used in about 85% of consultations as most patients at the clinic have limited language proficiency (Sodemann et al., 2013). A health technology assessment showed that the clinic overall saved health expenditures through coproduced solutions that reduced the number of emergency hospitalizations, home care, and medicine consumption (Ølholm et al., 2016).

2.2. Participants and data collection

We conducted the qualitative study in three phases (Fig. 2). The first phase involved participant observations of consultations to collect first-hand impressions of coproduction between health professionals and patients between February and November 2020. The researcher (first author) spent one to two days per week at the clinic. On these days, health professionals informed patients that had appointments about the study and asked for permission to be included. Any newly-referred or long-

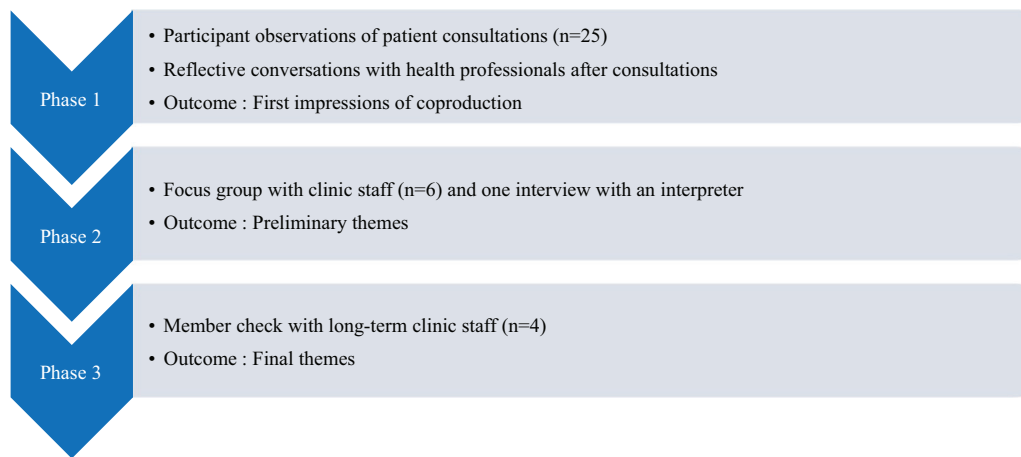


Fig. 2. Phases of data collection.

Table 1
Patient characteristics.

Characteristics	Number
<i>Sex</i>	
Female	15*
Male	9
<i>Age</i>	
< 29	1
30–39	10
40–49	9
50–59	4
>60	1
<i>Ethnicity</i>	
Syria	14
Irak	3
Turkey	2
Other (Somalia, Myanmar, Iran, Afghanistan, Vietnam)	5
<i>Time in Denmark (years)</i>	
0–5	12
6–10	6
11–20	5
>20s	2

*One patient was observed on two occasions.

Table 2
Characteristics of health professionals.

Participant	Profession	Sex	Age	Phase 1	Phase 2	Phase 3
HP 1	Nurse	Female	38	x	x	
HP 2	Nurse	Female	63	x	x	
HP 3	Nurse	Female	53	x	x	x
HP 4	Doctor	Female	60	x	x	x
HP 5	Doctor	Female	33	x	x	
HP 6	Nurse	Female	67			x
HP 7	Doctor	Male	61			x
HP 8	Social worker	Female	33	x	x	
HP 9	Interpreter	Female	43	x	x	
HP 10	Doctor	Female	29	x	x	

*HP=health professional

time patient over 18 years was eligible for inclusion. We approached 51 patients with varied backgrounds and health problems. Of them, 24 agreed to participate (see Table 1). One patient was observed on two occasions. The 25 observations were divided between three nurses, three doctors, and one social worker, which are shown in Table 2. The consultations lasted between 45 minutes and two hours. Interpreters were present in 21 of the 25 consultations, which were conducted in Danish. Of the interpreted consultations, 15 were translated to Ara-

bic, two to Turkish and one each to Somali, Burmese, Farsi, and Vietnamese. The observation guide (Appendix A) was inspired by the work of Spradley (1980) and included the items physical space, participants’ appearance, interaction dynamics, activities, and time during participant observations. Immediately following the consultation, we collected reflections of health professionals with respect to the visit process: co-assessing health status, co-deciding on treatment plans, co-designing how best to implement the treatment plans, and co-delivering the care leveraging both self-care and professional care.

The second phase aimed at deepening the understandings of findings generated in the first phase. A focus group was conducted with three nurses, two doctors, and one social worker after a clinic staff meeting. An experienced medical interpreter who had been translating in the clinic for over ten years also agreed to participate in an interview. The semi-structured interview guides (Appendix A) (Brinkmann and Kvale, 2014), informed by the observational data, included questions about the work environment, specific episodes of good/poor coproduction, patient contributions, and professional skills and competencies needed.

A discussion of preliminary themes in the authorship team (CRK, DSN, MSO, PB, CvP) revealed the need for a deeper reflection on the results. Therefore, in a third phase, we conducted a member check with the most experienced staff members (two nurses, two doctors), two of which are co-authors (MSO, DSN) of this manuscript. A member check explores the credibility of results by returning data to participants to check for accuracy and resonance with their experiences (Birt et al., 2016). The member check contributed with further practice-oriented insights, refinements of categories, and additional exemplifications.

All data were collected by CRK, a doctoral student with a public health background and solid experience in qualitative data collection methods. She had no other relationship with the migrant clinic. Handwritten field notes from observations were transcribed within 24 hours. The focus group and member check were digitally recorded and transcribed verbatim by the doctoral student. All data were anonymized to remove any identifying details.

2.3. Analysis

Data were analyzed using step-wise meaning condensation, which is based on hermeneutic text interpretation, exploring lived experience with the aim to create meaning and achieve understanding (Brinkmann and Kvale, 2014; Laverty, 2003). We coded emerging meaning units, which could be quotations, dialogues, or observation notes. These meaning units were then condensed in clusters and summarized in themes. Meaning condensation was repeated in phases 1 and 2. Member checking validated the already synthesized data and contributed additional practice-oriented insights. An example of the meaning conden-

sation as well as how themes evolved between phase 2 and the member check are shown in Appendix B. To ensure validity and reliability, the doctoral student kept a journal with ongoing reflections regarding the collection and analysis of data. Trustworthiness was further enhanced by involving different members of the authorship in the analysis and refinement of themes. The NVivo 12 software was used to transparently code and analyze the data, for example by regularly sharing and discussing the codebook and theme development with the research team.

2.4. Ethics and data protection

The study is part of a research project registered with and approved by the Regional Committee on Health Research Ethics for Southern Denmark (journal number: 19/16130). The study did not require approval by the Danish Data Protection Agency. Consent was obtained orally twice (through an interpreter if present); first by the attending health professional and again when the researcher entered the consultation room. Health professionals and the researcher assured patients that participation was voluntary and would not affect their treatment or therapeutic relationship. Data will not be shared to protect the integrity, anonymity, and confidentiality of the respondents.

3. Results

The analysis concludes with four themes on how health professionals view coproduction with immigrant and refugee patients: Coproduction requires a team effort of sense making; disentangling the chaos first; when everything fails - listen to the patient; and continuity - becoming part of the patient's story. Quotations from field notes are labeled O (observation) and quotations from the focus group or member check are labeled P (participant).

3.1. Coproduction requires a team effort of sense-making

The health professionals at the clinic shared a purpose of doing what makes sense for each patient.

They reported to continuously reflect on how to improve their practice. While sharing that vision, the clinical setup supported their coproduction efforts by allowing them to invest time and resources, think holistically, and thereby tailor solutions to patients' individual needs. They agreed that doing what makes sense came quite naturally, which gave their work meaning:

Nurse (P2): *I used to work in a department, where I often felt like I was handcuffed. I had to keep my hands down, focus only on a patient's physical problems, and disregard all of the social issues. Here [at the clinic], there are no procedures we strictly have to follow. I can pull the strings that make sense and this feels so good.*

All health professionals pointed out that it was crucial to have enough time to patiently and persistently co-assess a patient's health situation and life story, waiting until patients are ready to co-decide on priorities, or co-plan a patient's care and treatment plan:

Doctor (P5): *We have a patient who has been checked for everything. He always claimed his problem was not psychological but everything about him told us otherwise. Last week he had a consultation with one of the other doctors. She patiently kept repeating her suspicion of a psychological health issue. Others would have given up and close the case long ago. Suddenly he said: "Ok, but can I get help for this?" That doctor answered, "We will try!" Suddenly, he opened up and told us about all the terrible things that had happened to him.*

Next to the organizational support and resources, a working environment informed by a flat hierarchy and a readiness for interdisciplinary collaboration within the clinic and beyond enabled the coproduction of care efforts with patients. Frequent feedback discussions created room for exchange and appreciation of each other's expertise and roles. These

discussions often provided new perspectives or challenged existing pre-understandings. Showing vulnerability was legitimate, for example, by sharing errors or asking for advice.

Nurse (P1): *We have all been in situations with a patient where we felt completely stuck. Therefore, I am not scared to speak up. Nobody looks at me strangely when I ask for help.*

Nurse (P6): *I see myself sitting in the middle of a spider's web and the trick is to find what I call playmates on each outgoing thread – people that can help solve the issue. Because I am not an expert on everything but I can help find the people who can be helpful.*

3.2. Disentangling the chaos first

During initial consultations, nurses aimed at creating an overview of patients' health and life situations. Through communication tools designed around patient needs, they co-assessed a patient's health status, and life situation, making the patient narrative 'less messy'. A systematic, yet simple tool was the problem list, in which patients were given the opportunity to list all problems that troubled them:

Field note (O10): *It is the patient's first consultation. After introducing the clinic, the nurse encourages her to talk freely about all her worries. Hesitantly, she starts listing her problems: Undefinable, constant body pain; Worried, because she feels pressured to increase her weekly working hours; Constant headache, neck pain, and forgetfulness; A "shaky" heart (despite an inconclusive heart scan, the patient insists something is wrong); and ear pain and liquid discharge. It turns out, the patient had previously been treated for Post-Traumatic Stress Disorder (PTSD) but had forgotten what PTSD is or means. Eventually, the nurse repeats all problems listed and asks the patient to prioritize them. Together, they create a plan for the next consultation (the nurse will try to contact the patient's caseworker regarding working hours, PTSD clarification). Until then, the patient will seek out an otologist.*

The example above illustrates a co-created problem list and how it facilitated shared decisions for the upcoming care plan and shared responsibilities of activities for both patient and professional. Other tools used included the life story and family tree. The life story covered a patient's childhood, growing up, family life and relations, turning points, and other negative experiences. The family tree created an overview of family members and social network and their role in a patient's life. Using these communication tools took time, especially when interpreters were used, but eventually, they provided health professionals with a rich information base for co-planning upcoming steps of care. These open inquiries required health professionals to be able to navigate uncertain and ambiguous situations. Solutions were not always immediately evident and they had to be patient and accept slow decision-making:

Nurse (P3): *Our experience tells us that there always is a solution. Maybe it is not visible right now, but it will come. If it does not come, then we have at least tried. We need to endure being in that limbo of uncertainty without getting stressed by the slow progress.*

3.3. When everything fails –listen to the patient

All consultations started with the health professionals asking the patients, what they had on their mind or wanted to talk about. This approach contributed to a calm and safe space in which patients were not distracted or preoccupied with unspoken concerns. The abilities to listen and ask open questions, especially when using interpreters, were generally crucial for coproducing a patient's care. Often, patients would point out that nobody else had listened to them this thoroughly before. Some health professionals even considered the art of listening as the magic bullet:

Doctor (P4): *To put it in a nutshell, all I do is listen to them [the patients]. They are not used to being listened to - not in the healthcare sector and*

not in society. It surprises me again and again that listening to a patient is often all it takes.

Particular attention was paid to moments when a patient's narrative became entangled and scattered. Skipping certain parts of a life story could be a clear indication of experiences or memories that were suppressed or locked away, but could be of great significance for the health professionals to know. Paying attention to the gaps in a narrative often revealed clues for possibilities to move forward. The conversation below (Field note, O16) illustrates the unraveling of the underlying reason for a patient's reluctance to take an important lung examination:

Doctor (D): Are you afraid of the lung check-up?

The patient nods, hesitates to answer, and starts crying. The doctor is waiting patiently.

Eventually, the patient (P) says: I am afraid of dying during the examination.

D: Why would you be afraid of that?

P (hesitantly): My father passed away after complications during a chest drainage.

D: I am very sorry. It must be painful to be reminded of your father's illness. Did you avoid the examination because of your father or because you are afraid of becoming ill again?

P: Both, I don't want a tube down my throat. My father died when they pulled out the tube.

The doctor re-explains in simple words the purpose and procedure of the checkup. Eventually, they agree on the doctor informing the lung department about the patient's situation and making sure extra time will be set aside for the patient's appointment.

Another strategy was to ask open questions about activities of daily life, which would offer valuable clues about their physical and/or mental state. Asking these questions required considerable skill and sensitivity, it was *more than ticking off boxes on a standardized checklist* (P4, doctor). However, health professionals also acknowledged the challenge of learning to ask open questions given that their professional training had often focused on specific, targeted questions. Open questions were also used regularly to resolve deadlocked conversations; an approach one participant called *fishing for the good* (Doctor, P7):

Doctor (D): What can I help you with?

Patient (P): I just want to feel better.

D: What do you think is the prospect of you getting better than you are now is?

P (slightly smiling): Actually, I just do not want to get worse. (Field note, O4)

Here, the doctor and patient agreed on the goal of "not getting worse" and eventually co-decided on a care plan of occasional auto medication that suited the patient's needs. Letting the initiative flow to the patient by inquiring about her own perspectives provided clear leads for coproducing concrete next steps. Another tactic to re-divert uncomfortable or stuck conversations was to ask patients about, e.g., their children, their work, or childhood memories. This strategy of *getting a patient back to the safe shore* (Nurse, P3) provided an opportunity for a break and talk about something that inspired confidence and is illustrated in the following field note:

The nurse realizes that the conversation about deciding on a treatment option has come to a standstill. She changes the subject and asks after the patient's son who lives in foster care. The nurse asks several questions about his well-being and the patient's relation with her son. While talking about her son, the patient's facial expression and posture relax little by

little. She even starts smiling and tries to say a few sentences in Danish. (Field note, O20)

Interpreters were present in most consultations. They proved to be vital not only for mutual understanding but also for helping patients to articulate feelings and emotions. Health professionals considered interpreters not as a tool but as equal colleagues and as cultural mediators that were needed to establish trust and co-create a common understanding of a problem. In several consultations, health professionals provided patients with the opportunity of a private moment without the interpreter as the following quote shows:

Nurse (P3): We can immediately sense when a patient is holding back because there is an interpreter present. We should always ask in advance if there is anything, they want us to talk about without an interpreter.

3.4. Continuity – becoming part of the patient's story

Over time, patients and health professionals established strong trust relationships. They learned about each other's strengths and weaknesses as well as communication habits and preferences. In these well-established relationships, shared decisions and the planning and delivery of care activities became increasingly natural. The health professionals knew their patients' capabilities to contribute to their care activities and how to best possible support them:

Nurse (P1): In my experience, many of our patients really want to get better, be pain-free, and have a better life. Some need regular supporting conversations that help them reflect on their capabilities to get better. Most of them have some sort of resources to be part of their care process. We just have to take it in small steps.

The clinic had numerous long-term patients who came for regular checkups. For them, the clinic was a 'safe harbor' where emerging health or life-related issues could be addressed. Sometimes, roles of patient and professional became blurry and patients would relate to their health professional more as a friend or even family member:

Doctor (P7): For some patients, we have been like a midwife who helped birthing triplets [meaning solving their problems]. It is incredibly difficult to cut the string with them. For them, we are not just a doctor or a nurse, but a lifesaver. They do not easily trust others.

Health professionals were aware of the risk of patients becoming emotionally dependent on their respective nurse, doctor, or social worker due to often limited social networks. They had to constantly reflect on the balance between being a professional and a 'confidant'. On the other hand, enduring relationships between patients and professionals sometimes created new opportunities such as patients becoming empowered to participate in patient panels or as patient examples in teaching sessions.

4. Discussion

4.1. Discussion of results

Our objective was to describe the actual work of coproducing healthcare service with immigrant and refugee patients from the professional perspective. We collected observation and interview data at an interdisciplinary outpatient clinic for immigrants and refugees. The work of coproducing healthcare service with immigrant and refugee patients demands health professionals to engage in a *team effort of sense-making* and that they help patients *disentangle the chaos first*. Further, *when everything fails* – they need to tune the skill to *listen to the patient*, and create *continuity* – and in the process, they embark on *becoming part of the patient's story*.

Our results are consistent with other research on good healthcare practice for immigrants. A study conducted with health professionals

in 16 European countries (Priebe et al., 2011) showed that organizational flexibility with sufficient time and resources, good interpreting services, and working with families and social services are critical components of good practice. Moreover, a review on the effects of multidisciplinary teams (Epstein, 2014) found that enhanced communication and teamwork counters 'silo-effects' and enables professionals to optimize their performance, improve patient outcomes and job satisfaction. Flexible, innovative approaches to coproduce meaningful solutions with patients need organizational support as they are more likely to thrive in organizations that allow employees to take risks and try new things (Greenhalgh, 2018). They will often collide with pressures of standardization to improve efficiency (Farr and Cressey, 2015), but as Elwyn et al. (2019) put it "where complexity occurs, so does the need of tailored approaches".

The communication tools used at the clinic were designed around patient needs (instead of professionals' needs) and provided the 'personally significant evidence' (Greenhalgh, 2018) needed for co-deciding and co-planning patient care. These tools allowed patients to take the lead in inviting the health professional into their life (Danish Ministry of Health, 2011) and thereby reducing the power asymmetry between patient and professional. These communication tools enabled respectful interactions, a deep understanding of each other's expertise and values, and the cultivation of shared goals and responsibility, which are described as requirements for good quality service coproduction in Batalden et al. (2015) conceptual model. What is more, going through a patient's life story and family tree help patients to draw connections between illness and family dynamics of life-changing events (Launer, 2017). Health professionals need narrative competencies to absorb and respond to 'heavy' and complex stories of immigrant and refugee patients so that they can quickly and accurately hear and interpret which story or impression a patient is trying to convey (Charon, 2004). They need to be able to tolerate uncertainty, and ambiguity in coproduced decisions and care; attributes which typically are considered a weakness (Domen, 2016) or a threat (Norton, 1975) as health professionals are expected to 'fix problems'. However, we believe them to be critical competencies for coproduction as they seem to allow for slower processes in care instead of jumping to quick conclusions. Similar to our results, Wayne and colleagues (Wayne et al., 2011) found that medical students' tolerance of ambiguity was significantly associated with maintaining a positive attitude towards underserved patients. Tolerating ambiguity and uncertainty improves health professionals' well-being and the way they practice. Accepting one's own imperfections permits one to better tolerate them in others and to recognize the need for empathy, respect, kindness, and curiosity (Shapiro, 2008).

Health professionals cannot have an in-depth understanding of every immigrant patient's cultural background. They can, however, listen and respect preferences and values (Hasnain et al., 2011). Our findings emphasized the importance of listening, which is in line with previous research (Brämberg et al., 2010). Listening can determine outcomes, reduce stress, improve joint decision-making, and strengthen patient confidence and relationships (Jagosh et al., 2011). Our findings bring practical recommendations for listening and asking open questions. These include picking up on unspoken gaps, subplots, silences, anecdotes and metaphors, and re-directing of deadlocked conversations. Moreover, communication training for health professionals cannot be reduced to the skill of attentive listening, it must also address the values, beliefs, attitudes, and intentions of professionals and patients (Jagosh et al., 2011). Coproducing a service in cross-cultural patient encounters often involves the hybrid use of knowledge of family values or other traditional perspectives and the knowledge and capabilities that a patient may personally contribute in a process of shared-decision making (Dobler et al., 2017).

Our findings also resonate with a recent study on relational continuity in general practitioners (Murphy and Salisbury, 2020). Care continuity was associated with professional knowledge about the stories of a patient, trust and respect, consistency of advice, responsibility, and ac-

tion; all of which are crucial foundations for coproduction. In our study, relational continuity allowed immigrant and refugee patients and health professionals to co-develop a meaningful narrative and decide on treatment plans based on patients' preferences, willingness, and capabilities to be involved in their care. Having in mind that patients with mental health issues tend to be more emotionally dependent on the professional (Morgan and Clark, 2010), health professionals yet managed to turn their relationships into a kinship of human persons, built on kindness and authenticity (Ballatt et al., 2020).

4.2. Strengths and limitations

A strength of this study was the combination of direct observations, interviews, a focus group, and having preliminary results member checked by the health professional participants. A notable limitation was the absence of patient perspectives. Initially, we tried to include patient experiences but three pilot interviews did not result in rich narratives, mostly due to a lack of trust and confidentiality in the researcher. Besides, patients were tired after consultations or too new to reflect on their experiences at the clinic. The perspectives of patients were elicited in another study within the same research project (Radl-Karimi et al., 2021). A further limitation of our study was the sampling of participants. We were able to include all health professionals of the migrant clinic. However, patient participants for observations were sampled conveniently, according to the days the researcher was present at the clinic. Being able to observe patients also in other healthcare settings or during their daily routines would have added strength to the analysis. This was however not possible because of the restrictions related to the Covid-19 situation. One co-author (DSN) participated in the focus group discussion and the member check. Another co-author (MSO) participated in the member check. As both also work in the clinic, they were able to add valuable critical observations and further exemplifications due to their extensive experience on working with immigrant patients. Researching in their own organization, they were aware of their dual roles of researcher and study participant and needed to align their own subjectivity with their attention and understanding of the data, the situation, their judgments, and their responsible actions (Coghlan, 2019). To further ensure validity, results of all three data collection phases and particularly the final themes were always discussed in the entire research team. Regarding the transferability of our results, we consider our study setting a best-practice example for person-centered healthcare that posed a rich source of knowledge. It is our sense that our results can be meaningfully translated to other healthcare settings and other groups of patients, as complexity not only is confined to immigrant and refugee patients.

5. Conclusion

We believe this is the first study to describe the conditions for coproducing healthcare by immigrant and refugee patients and health professionals. The results reveal an interdisciplinary work environment that fosters values of doing what makes sense for each patient and allows health professionals to act autonomously, flexibly, and creatively. Using communication tools designed around patient needs, create optimal conditions for coproducing healthcare service as health professionals empathically validate and integrate patient experiences. However, they need time and patience to follow plots and identify cues in patients' narratives. They need to have advanced listening and relational skills to use effective tools and to tolerate ambiguity and insecurity. Relational continuity facilitates long-term coproduction but also bears the risk of emotional dependency on the health professional. Our results contribute clinically relevant results to the growing body of research on healthcare coproduction by patients and professionals.

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Availability of data and material

No datasets are available from this study owing to the consent given by participants, which limits data to the research team only.

Declaration of Competing Interest

The following statement is also included in the manuscript in Section 4.2 and the attached declaration of interest: One co-author (DSN) participated in the focus group discussion and the member check. Another co-author (MSO) participated in the member check. As both also work in the clinic, they were able to add valuable critical observations and further exemplifications due to their extensive experience on working with immigrant patients. Researching in their own organization, they were aware of their dual roles of researcher and study participant and needed to align their own subjectivity with their attention and understanding of the data, the situation, their judgments, and their responsible actions

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jmh.2022.100101.

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