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The Cultural Dimension of Clinical Vulnerability: Repeated Access to Emergency Units and Discontinuity in Health and Social Care Pathway

Laura Bertini-Soldà 

Department of Business Economics, Health and Social Care, University of Applied Sciences and Arts of Southern Switzerland, 6928 Manno, Switzerland; laura.bertini@supsi.ch

Abstract: Swiss health and social care system is complex and is based on universal coverage. However, discontinuity in health and social path and repeated access to emergency units are symptoms of inequity. The aim of this paper is to highlight the interactions between vulnerable patients with socio-sanitary actors to propose some innovative solutions to promote social justice. A six-month ethnography of 15 vulnerable patients' health and social transitions in the region of Ticino Canton in Switzerland gives new insight into conflict situations in assistance relationships, where reciprocal stereotyping between professionals and patients undermines continuity of care. The cultural dimension of health and social institutions is identified in the problem-solving approach which is legitimized as the only one for dealing with complex situations. The analysis shows how clinical vulnerability relates strongly to an unmanaged so-called liminality phase. Culture is an invisible dimension in care, but its effects on equity are major. Two possible interventions are discussed, which are culturally informed reorganization of the care network and collaboration with a sociosanitary cultural mediator.

Keywords: social determinants of health; social justice; equity; continuity of patient care; medical anthropology; migrants



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1. Introduction

This article shows the discontinuity of the health and social path of vulnerable patients and focuses on the cultural dimension of this problem. An action research project “HSBridge: improving equity and continuity in health and social care” documents the therapeutic itinerary of 15 vulnerable patients in Ticino Region, the southern Canton of Switzerland. First, there is a presentation of the background of the project with a particular focus on clinical vulnerability. Second, the description of the methodology followed by the ethnographic results concerning health and social transitions and the way patients experience them. The focus is on the cultural and symbolic dimensions that are made invisible in clinical and social assistance procedures. The hypothesis that emerges is the priority of the comprehension of the cultural dimension in the management of clinical vulnerability and the need for culturally informed innovative solutions. This article also discusses the development of a socio-sanitary cultural mediation service that integrates the sanitary and social dimensions of vulnerability within an anthropological approach, especially to migrant patients.

2. Liminality and Vulnerability in Health and Social Care

Ticino Region is the southern Canton of Switzerland situated on the border with Italy. This Canton has the highest rate of repeat visits to the emergency unit, with a caseload composed of vulnerable patients [1]. Vulnerability is a concept related with the model of health determinants and, therefore, often approached from a social medicine perspective [2–6]. Vulnerability is not a rigid condition of difficulty that affects a small segment

of the population with a determined set of characteristics; it is a potential experience of every individual [4]. Anyone could go through a period characterized by vulnerability, as a temporary experience of his or her own biographical path [5]. The condition of vulnerability may arise because of the emergence of stressful events, against which the person must activate resilience strategies, i.e., the ability to constructively activate their internal and external resources [6–9]. It is from this theoretical framework that social medicine develops, with its characteristic of wanting to understand social factors on health with the aim of acting on patients' inequalities in care [3]. Indeed, social medicine broadly considers health, outlining numerous individual and social factors, including poverty, education, environment, income, and others.

2.1. Migration and Social Determinants of Health

The experience of migration can be a factor that influences all the other determinants of health in positive or negative ways depending on the migration trajectory. Asylum-seeking affects the individual's ability to activate resilience strategies and this can contribute to the emergence of a condition of vulnerability in health [10]. The effects of asylum-seeking and refugees' health vulnerabilities are a medicalization of social distress, repeated access to the emergency room, problematic and fragmented continuity of care, non-sharing of treatment pathways, different representations in terms of health and illness, and misunderstandings of the communication level [11].

The needs and resources of migrant patients when they enter the health system are heterogeneous and could not be understood by generalized ethnic groups or national origin stereotyping. Beyond purely clinical and biological factors, including age, gender, and other genetic characteristics, there are other elements of equal importance, including lifestyle, education, social and economic status, and informal and formal social support networks. Considering these factors in relation to people with a migration background is the core of clinical transcultural competencies. The clinicians must assess the possible language and cultural barriers, the possible scarcity or non-existence of a social support network, precarious working conditions, psycho-social traumatizations derived from the migration path, and difficult housing conditions, often characterized by collective accommodation. In addition, clinicians must be aware of the institutional and political context within their actions and be able to understand the possible unawareness of patients regarding their rights to access care [12–16].

All these elements can contribute to bringing the patient into a condition of clinical vulnerability, to the renunciation of care, and consequently, to late access to the health system [17]. When health status is particularly compromised, health professionals have to face onerous, complex situations. Vulnerable patients are often invisible to family doctors, who act as a pillar of the Swiss health system. Further, hospitals reveal the existence and complexity of these cases, with challenges such as properly detecting them, having to mend a therapeutic alliance without having the right timing, and having to reintegrate them into a territorial network, with the aim of creating a long-term social and health project. According to Ranci, "Vulnerability identifies, in other words, a life situation characterized by social frailty that exposes one to suffer particularly negative and harmful consequences in the event of problematic situations" [18].

2.2. Vulnerability and Liminality in Migration Experience

Turner's concept of liminality helps to better understand the condition of vulnerability as a process. From an anthropological perspective, patients, in this situation, have to first deal with their identity's definition to be able to cope with stressful life events. The social and health situation "in betwixt and in between", described below, limits the capability of people to cope with it. As Gold pointed out when referring to Turner's theories, the "in-betweenness" of modern societies sets people in a prolonged state of liminality because of a lack of rituals of closure. Even more, this is interesting to observe for displaced migrants that experience a biographical rupture, and the integration in European host societies

is not “easily resolved through rituals of incorporation” because of an increasingly long and undefined time of structural reconfiguration that produces in this context a so-called “cross-section of ‘non-citizens’”. This liminal situation is experienced more as a ‘ritual of degradation’ within the process of asylum, and Switzerland is not an exception [19].

3. Materials and Methods

The data presented here come from the action research project “HSBridge” project, designed by a Swiss Hospital near the border and the University of Applied Sciences and Arts of Southern Switzerland. For 5 years, the Italian border of Ticino Canton was often under pressure for migrant arrivals. The Cantonal Hospital of Mendrisio is the more involved in the first asylum seekers’ healthcare. In this hospital, in 2017, the sanitary board decided to integrate a “Cultural Mediation Service” to manage the cases of migrant patients. This “Cultural Mediation Service” differed from the Mediation Agency that provides intercultural interpreters with migration backgrounds as mediators to health, social, and school institutions in this region. The “Cultural Mediation Service” of the hospital is a transcultural service with an anthropological approach to health and illness. This service is also responsible for managing the involvement of interpreters in healthcare settings. The “Cultural Mediation Service” of the hospital was a pilot project for three years; the aim was to improve equity in the hospital health care for vulnerable patients and, most of all, migrants. The internal assessment of the pilot highlighted that the core activity to improve equity for vulnerable patients is to ensure continuity of care. The need for the service to have a more developed approach outside the hospital, before and after the hospitalization, is the starting point of this action research project.

3.1. Research Design

The project has two phases, as follows: the first is the study of 15 patient interactions with the main actors of the network for 6 months, and the second is the creation and implementation of solutions in collaboration with the health and social regional network. To identify 15 patients, the following criteria related to the concept of vulnerability were addressed to the Emergency Unit and the Medicine Department:

- Have recorded, repeated access to hospital emergency rooms in the last 6 months from the start of the project, or re-hospitalizations in the 12 months preceding the project; (re-hospitalization means a hospitalization motivated by the same problems treated in a previous visit as judged by doctors as a case of mal compliance).
- With a situation of polymorbidity and/or chronic illness and who have a compromised social and/or economic situation that affects access to the social/health network with consequent problematic discharge.
- Excluding cases that, according to doctors, reveal a geriatric type of frailty syndrome.

The 15 cases included families, adults, and unaccompanied minors. Data collection took place weekly for the first month, then bi-weekly or according to agreements and the special needs of people.

3.2. Methodology

The methodology applied in this study in the field of social justice and public health refers to symbolic interactionism [20–22]. Ethnographic data were collected by participant observation and recorded in a journal. After data collection, the discourse analysis [22,23] was organized as a team-based collaboration. Every month the research teams met together to exchange about the main topic that emerged from the social and sanitary paths. This intermediary analysis helps researchers to focus more on pressing topics, and discuss the relationships with the informants, the quality of the observations, and the possible barriers to accessing information. Every meeting was recorded in a second journal and, at the end of the period of observation, the team did a final analysis of the journals and resume the main transitions and needs of the patients, the actions they did, and the response of the system. In other words, the analysis focused on what was the important theme for the

patient, how he/she represented the problem, how he/she intended to solve it, who was involved, how the other actors perceived the problem, what solutions were found, and how they were implemented. The analyses allowed an understanding of the possible gap between the representations of patients and the representations of the social and health actors in the same situation. This made it possible to deconstruct the process of health and social care interactions to understand where and how continuity is lost.

4. Results

4.1. Health Transitions: Defining Diagnosis and Treatment

There are two types of health problems, acute and chronic. Sometimes acute problems, which prompt people to go to the family doctor or the emergency department, turn out to be symptoms of a problem, which may well be acute, but in the case of vulnerable people, they are often somatization or signs that quickly lead to chronicity. The medical literature defines this kind of patient as a 'big consumer of emergency services'. For this reason, in the case of vulnerable patients, the acute problem approach is rarely effective [24]. The medical model based on the treatment of an acute disease encounters difficulties in the presence of chronic diseases, which are not curable, require long-term management, and generally need a substantial contribution from the patient in the therapeutic process, as in the case of diabetes [25].

4.1.1. Illness Cultural Negotiation

The sharing and agreement between professionals and patients on the definition of the health problem is fundamental, especially when people are not yet familiar with the healthcare system and the functioning of biomedicine. It emerges from all the case studies that the representation, or rather, the expectation concerning Swiss doctors and medicine is to be "adjusted" in order to solve the health problem, to act on the body by first giving a name to one's disease (specific diagnosis) and then a cure (decisive treatment). In general, patients perceive health problems as a barrier to social integration activities. Sometimes they represent a stigma; other times, because the worry about a possible inauspicious diagnosis or the loss of autonomy frightens and worries patients, especially in the case of asylum seekers, the first period of arrival represents a phase of uncertainty, such as the absence of accommodation. The therapeutic practice bases the diagnosis on repeated tests over time and the methodology applied is a procedure of hypothesis generation and verification by exclusion. Production of objective anamnestic data by a set of translations [26] is the core of clinical reasoning, even if these 'objective' data are not always 'visible' to the patient, so to speak, unless the doctor makes them clear. For example, a patient could perceive a medical error in diagnosis when his doctor in clinical reasoning will exclude a pathology and order a new examination. This misunderstanding can fuel an idea of discrimination in the people facing a biographical transition and living in social marginalization. A radiological image or a scan is perceived as a clinical investigation, whereas the administration of a therapy to check the patient's response is not.

These dynamics of cultural misunderstanding between patient representations, expectations, and clinical practice are omnipresent in doctor-patient interaction, but the impact on patients experiencing an uncertain situation is all the more relevant at both the health and social levels. Data showing the social impact of the unmanaged illness event and vice versa, the uncontrollability of the illness in a provisional social situation.

4.1.2. Health and Illness in Temporary Environments

The research sample includes people who were not in a stable housing situation during the observations. These people, who were in the process of waiting to find their own accommodation, were guests in collective shelters—for refugees or for the homeless.

The first example relates to a first meeting with Carlo, a refugee with provisional permission, living with his wife and two children in a collective shelter. Housing status, defined as the size of the living space, perceived safety, possibility of privacy, proximity to

basic services and public transport, to school, friends, and other family members, as well as having good neighborly relations, is an important determinant of health, both physical and mental [27]. Swiss migration policies for refugees require an initial period in a shelter and then a transition to an apartment. The question of how and where a host society locates refugees is a crucial point. In Switzerland, the idea of a controlled migration that preserves the Swiss identity is deep-rooted in discourse, politics, and policies [28]. Adherence and acceptance of the rules of the integration project, in the case of the refugees, is a *condicio sine qua non* to receive welfare benefits, and as Gold pointed out, the rites of passage in this context are more like to be defined as degradation ceremonies [19].

4.1.3. Political Situation

Asylum seekers that receive a positive decision in Switzerland are attributed to a Canton (there is a calculated equal distribution between different regions). According to social operators, refugees that arrive in Ticino Canton are first hosted in collective shelters for a period varying from 3 to 8 months. In this shelter, they have a room, a collective kitchen, a social worker's office, and a nurse ambulatory. There are two main figures, the case manager, and the job coach. Refugees begin the integration path there, the case manager and the job coach must plan and organize language courses and training stages and they must evaluate and measure the integration level of refugees. When refugees have met a series of objectives and criteria, they are eligible to get an apartment. After 3 or more months they must move again, as the Cantonal Bureau for Refugees indicates. During their stay in the shelter, refugees build up a series of conjectures to explain why some people exit the shelter first of others and most of all they are stressing the fact that some people can stay in the Lugano region, where the shelter is located, while others are sent to another city of the region or in the periphery.

4.1.4. First Personal Situation

In the first encounter in the camp, Carlo introduces himself and the problems that stress him. First, he emphasizes the problem of tremors that several different doctors are evaluating neurologically. For him, it represents a handicap to be able to make friends in the collective shelter and evokes the dimension of shame. He cannot even follow Italian courses, and he also highlights his difficulty being among people because this causes him a lot of anxiety. From 2019 the political procedures include some particular steps to show the degree of integration (and the right to leave the collective shelter to an apartment). Carlo pointed out that when he goes nervous, he trembles even more. At the beginning of the observations, Carlo was very anxious because he could not go to Italian classrooms, and he thought that the procedure to exit the collective shelter was blocked for this reason. He felt anxious and responsible for the uncomfortable situation of his children. The second theme is the presence of his relatives in another Canton. He would like to join them and did not understand why he could not stay close to them. He argued that surrounded by his (large) family, his physical discomfort and the stress that aggravates it are lessened and he could do some activities. He stressed the fact that in his everyday life, before fleeing the war, he worked from seven in the morning to the evening as a mechanic in a factory.

4.1.5. Relationships and Ruptures

The social dimension, i.e., the relational environment, are factors that Carlo defines as fundamental in the management of the illness. Carlo stands by, waiting for a definition of his neurological problem from doctors, a disease that the patient first tries to control by managing and reducing the symptoms that are particularly disabling and do not allow him to take even the first steps toward integration. The first step was to ensure that Carlo, or the social professionals of the shelter inform the doctor of the need to be medically excused from the Italian course. It appears to be an easy step, but observation shows that this communication event could be more complex than one could imagine. In fact, Carlo has done four visits to the Neurology Department, but always with different medical assistants.

First, it is necessary to reconstruct his health itinerary and then to ensure that all the professionals, even if they share letters of discharge and clinical records, know the information about the entire situation and the evolution of Carlo's health and social conditions.

This fragmentation of the health and social itinerary represents a loop. The next case shows the socio-healthcare impasse, as well, in which a person—and their family—found themselves during the diagnostic phase and in the treatment of a chronic problem.

4.1.6. Second Personal Situation

When Orazio entered the project, his situation was very complex to unravel and describe both on the health and social sides. Since there was a diagnosis in progress to verify the onset of Parkinson's syndrome or other neurodegenerative pathologies, the path of integration and movement from the collective shelter to a flat was uncertain and not clearly defined for him and his family. Orazio's perception is that he will stay in the shelter for two or more years and this is a stress factor for all the family members. Orazio's wife was pregnant—she was in the first semester—and they have two children. They lived in a single room in the shelter for a year.

For Orazio, the process of learning a language and the information needed to live in Switzerland is taking a long time compared to others, due to problems related to memorization and the symptoms of a probable post-traumatic stress disorder. The time necessary to reach the required competencies to leave the shelter and start a possible professional activity is longer; without a diagnosis, it is not possible to establish with precision which supports can facilitate the management of the symptoms and speed up the integration process of the whole family. At the same time, the patient's symptoms are extremely linked to perceived stress, which increases day by day in this uncertain condition.

4.1.7. Iatrogenic Effects of a 'Problem-Solving' Approach

Social and health workers adopt a problem-solving approach, they try to organize hospital appointments, and, in the middle, they try to manage the tensions that are more and more visible in the couple. Each time the patient does not adhere to planned activity or treatment, professionals reinforced a culturalized lecture of the situation, this reinforces the stress and the difficulty of Orazio and his family, and makes the situation worse.

Orazio is suffering from the increasing stress that, in turn, worsens his health condition. The stress is multidimensional and is generated by the uncertainty of a bad diagnosis. For example, he asks himself: will I be cured? Will the illness get worse? Will I be able to work? Will I be a burden on my family? He suffers from a lack of knowledge of the social-health systems, and moreover, he does not understand why he has to keep doing the same test periodically. Daily, he compares his own situation with that of other people who have passed through the collective shelter; in particular, he fixates on the fact that other households have left the collective housing more quickly. He does not have any idea of the continuation of the integration process, which is also reinforced by his discouragement regarding language learning. This difference in the language learning between him and his wife raises further tensions within the family unit; he wonders about children that could realize that something is going wrong with their father. All these stress factors are reinforced by living conditions inside the collective shelter: limited space inside the house and the presence of other people in the shelter, the absence of employment, and chronic insomnia experienced in a room shared with his pregnant wife and his two children.

4.1.8. Identifying Health-Related Cultural Needs

As time passed, the fundamental importance of the diagnostic progress for the definition of a project for this family emerges. This statement is valid for both the members of this family and for the operators of the social welfare network who are called to define and prepare for the moment of transition. In fact, the case manager has to prepare the date for leaving the shelter and the consequent predisposition of the support network necessary to help the family in their new home, but the more time passes, the more the relationship

is worsened between professional and patient, with an increased risk of loss of continuity of care.

A study carried out in a Geneva Hospital about measuring physicians' and medical students' attitudes toward caring for immigrant patients stated [29]:

"(. . .) we were surprised that doctors with a higher percentage of immigrant patients actually put a greater onus of adaptation on patients and less on the hospital or physician. We can only speculate as to the reasons for this finding, but it may be a reaction to the need for additional time, energy, and resources when caring for large numbers of immigrant patients. Physicians may wish to reduce some of that burden by putting the responsibility back on patients to adapt to the host country health care system." [29] (p. 468)

Deadlocks in the integration progress caused by health problems and the problem-solving approach negatively affect psychological health and encourage risky behaviors such as consumption of psychotropic substances in the form of self-medication, dysfunctional eating behaviors, and further recourse to emergency services, including admissions to psychiatric facilities. The data suggest also that a preventive action focus on continuity and integration between social and health problem definitions and management could avoid illnesses and negative relationships becoming chronic, i.e., the symmetry between health and social care providers and vulnerable patients.

4.2. Defining, Understanding, and Incorporating a Diagnosis

In both cases, Carlo and Orazio, the prolonged health and social liminal phase due to uncertain diagnosis and invalidating symptoms, negatively affected all family members. Defining priorities, considering the different needs, and designing a pathway for the integration of all these people becomes impossible without integrating and mediating with the health dimension.

It is interesting to note from another case study that sometimes, even when the living environment is temporary, transitional, and includes a clear diagnosis, the close link between planning a social pathway and adherence to treatment can be problematic. This leads to the assumption that the transience and uncertainty of the transition to a situation of stability and autonomy is a major risk factor in the field of disease management and the health of vulnerable patients.

4.2.1. Third Personal Situation

The clinical history of Miss Luisa's heart attack is a good example within the 15 case studies. Miss Luisa came to Switzerland for work one year before her hospitalization. She worked as a caregiver for 1 year for a family in the north of Ticino Canton but found herself unemployed after 11 months of work (without entitlement to unemployment benefits). Due to the nature of her work, she found herself simultaneously without accommodation and agreed to cohabit with a man she had recently met. A few weeks later she left the emergency cohabitation due to, it seems, domestic violence. The woman found a place in a women's shelter in the Mendrisio region, then after discharge, she went to Casa Astra, one of the rare shelters for the homeless in the region. Her difficulties are the living environment, and recovering her own space and personal belongings. She cannot stand the place, the dirtiness, which she says is significant, and sharing rooms with people who do not stay quiet at night. She is afraid to take the bus because she lived through the events of the earthquake in Marche in the past, her native region, so her mobility is difficult. Before, she was working as a caregiver in a family. She reports being very frightened by the situation and sleeps poorly. She misses her personal belongings more than anything else, she talks about her belongings as a necessary set of things that she has slowly managed to scrape together with great effort. All her personal belongings are in the hands of this man who has changed her locks, and she does not know what to do.

4.2.2. Disorientation and Lack of Control

The discourse of Miss Luisa highlights in this phase of vulnerability that she does not have control over her situation; she is preoccupied with being associated with homelessness and the dirtiness of this environment and situation. She is concerned with her identity and feels disorientated.

During this time, she missed several rehabilitation appointments. The physiotherapists in the regional hospital had no idea about her social situation and simply waited for her next appointment. She explains that while she was attending physiotherapy treatment, she also had an additional operation (balloon). This was an unattended treatment, and she felt very confused and preoccupied by her health situation. She thought that she was slowly reducing her reliance on pills, but she has been prescribed more and more of them. She had already begun wondering about her diagnosis. The fact that a heart attack came by surprise presented the feeling of an uncontrolled event, an accident. For this reason, a treatment that she did not expect gave her anxiety and froze her capacity to cope with the situation. Another problem she had was that she could not walk to the hospital for her physiotherapy appointment if it were raining. It was too much for her. This “too much” is related to the fear of having another heart attack on the road during the walk versus the hospital. When she found an apartment, she could not continue the physiotherapy sessions because the period of recognized rehabilitation treatment had expired.

4.2.3. Clinical Path Disruptions

For Luisa, because of her vulnerability, it is difficult to give continuity to the post-operative rehabilitation path. She is facing a phase of extensive reorganization of her life in Ticino, and she has a precarious state of health. She needs to find balance. This transition includes defining a location to live in the light of her new living situation, finding a flat, and redefining her daily life as a whole, including eating habits, lifestyle, tobacco control, and daily rhythms. In addition, there is the fact that Luisa finds herself in a context with no informal support network and no relatives or close acquaintances who can support her on various fronts.

4.2.4. Identifying Health-Related Cultural Needs

After retrieving her personal belongings and organizing her own living space, Luisa began to process the situation positively and follow the advice of the cardiologist. By quitting smoking, she gained weight. The challenge is to manage the excess weight by walking and getting out of the house regularly. This issue is known in the literature in the field of cardiology:

“The study of the relationship between stress and cardiovascular health is made more complex by the fact that the physiological effects of a stressful event are determined not so much by the situation itself, but rather by how it is perceived by the individual, as well as the type of strategies he or she puts in place to manage and reduce stress (coping strategies). In the field of cardiology, it has been observed that strategies aimed at managing the emotional reactions following a CV event are a prognostic factor and thus help determine the recovery time from an acute CV event.” [30] (p. 106)

4.3. The Pathogenic Dimension of Unaccomplished Rites of Passage in Social Context

The data collected on other patients allow further investigation of the issue of living situation and environment. These cases concern patients from the asylum sector who are already living in a flat in the area. The longed-for transition to the flat is regulated and codified. On a more symbolic level, people represent this transition as a moment of change and rediscovered autonomy, normality, the end of promiscuity, and the dynamics of managing intimacy and living together in collective spaces. People have the expectation of rapid and positive social and work inclusion, and the expectation of a job to provide for their subsistence made possible by the exit from the shelters and foyers that are generally located on the outskirts of towns. The way people talk about it in the previous phase

suggests a real rite of passage ([31]); people are waiting and expecting a change of identity. The physical arrival in the flat does not mean an immediate inclusion in a professional project or the obtaining of a job in a short, determined period. This makes it a rite of passage diluted in time, with a protracted liminal phase and, therefore, dysfunctional in terms of the health of the most vulnerable people. After a short time in the flat, it is common for the person to realize that little has changed in terms of their identity, “discourse” and interaction with the operators, and this gives rise to a certain sense of disorientation, often resulting in a feeling of discrimination. Despite the passage to the flat, social inclusion does not take place automatically; the refugee may continue to feel isolated and discriminated again because the perception is that of being “stationary”.

4.3.1. The Time of Liminal Phases

The topic of time is a transversally evoked and omnipresent factor. A suspended time, which sometimes becomes a pathogenic element, leads to somatization in vulnerable situations. It is properly a liminal time following Van Gennep [32] in his description and analysis of rites of passage. It is a situation where time is suspended and where “one is no longer as one was” and “one is not yet as one should be”. This type of situation, according to this analysis, if not framed socially and symbolically can quickly affect people’s mental and physical health. Two examples are particularly representative in this sense.

The planning of a training course is, in fact, the theme that emerges most strongly with Brenno and Ugo.

4.3.2. Fourth Personal Situation

Brenno has a chronic illness, the acute phase of which was managed a year earlier in the hospital with both in-patient and regular outpatient care. The disease was under control at the time he started the integration process. From the patient’s point of view, the disease was cured, although with a metaphor, health professionals explain to him that it is always present, even if it is dormant. His doctor defined Brenno as a very attentive patient, he always took all the prescribed therapies in a precise way and reported symptoms correctly. An interesting moment of the path was when Brenno went through an orientation interview and expressed the need to be in control of the situation:

“Having a plan in mind is important; it is the most important thing! You always have to have a plan A (what you want to do) and a plan B with other possibilities because plans never go straight! So many things happen, situations change, and you have to be ready to adapt. Adapting is important. My path here has a point 0, when I was in Chiasso, then a point 1 in Camorino (or Castione) and now a point 2 in Mendrisio, so much time has passed, so many expectations and it has not been a linear path. I’ve had to do a lot of things but always thinking that I was doing something to move forward, never to go backwards. In my condition, you cannot afford to go backwards, never! Maybe you don’t get to the point where you wanted to be with the path you had imagined and, in the time, you had thought of, but you must never take a step back, a “step back”, in the path because you have to go forward, improve a little bit and get closer to your goals. (...) What I have learned on my journey is that you must not stand still! You have to keep moving, keep doing things, keep being active and confident, and in my situation that’s the way it has to be. In the hospital in Bellinzona when I had the perception that everything was stopping, that I was in Switzerland but that I wasn’t following my dream, I was in hospital and I couldn’t do anything, I decided to stop. In my situation it is the only way, if you are passive, if you stop, you let the disease conquer you. This must not happen, I have to go on despite everything, sitting still does not help at all, you must not remain at the mercy of misfortune but take your destiny into your own hands. I want to make it on my own, I mean with work! I want to support myself, that’s the goal! I was given a base to start from, now I have a house, before that I received other help, I will receive money until I can support myself and for that I will always be grateful. My journey started a long time ago, I have had a lot of life experiences, I could write a book with the experiences I have

had, the encounters, the situations I have seen, so many things. " (From the Journal of Brenno, April 2021)

A month later, Brenno was waiting to know which possible training projects were available for him. Meanwhile, he received institutional letters about his rent that he did not understand and suspected that he did not receive the same possibilities as other young refugees for training and finding a job. He is isolated and even if he is in his apartment, he does not feel that the attitudes of social operators differ from those he meets in the shelter. The job coach described Brenno's competencies and gave him three possible training courses based on a report that she received from the shelter's job coach. He does not feel that the social operator recognizes more integration competencies in her assessment, and for this reason, he feels discriminated against. During this time, his sanitary condition has worsened; the specialist will confirm this evolution, but it is impossible for him to link it with the social situation.

4.3.3. Stereotyping

The social and health professionals will define as "cultural" his negative reactions and attitudes, reinforced by a stereotyped gendered analysis. Like in the situation of Orazio when the conflicts with his wife were increasingly violent. The analysis of the process of misunderstanding shows on the other side the strong causality of Brenno's loss of control caused by the problem-solving approach to his health and social network.

4.3.4. Fifth Personal Situation

Below is the theme of "standing still" that was found also in the case of Ugo, a young Afghani man whose itinerary was observed for more than one year. In this case, the patient was treated for physical diseases and mental disturbances for 3 or more years. After going to the apartment, Ugo felt tired and, even if he said that he is always thankful to Switzerland for the help it provides him, he sometimes cannot keep to the doctor's appointments or to the meetings with his caregivers, instead staying at home. He feels burdened by the fact that he cannot decide about his working future without depending on the job coach. He refers to a specific experience where he had to take a test together with other job applicants to access a job in a social laboratory. Ugo feels "punished" for being half an hour late. When he argues about the discrimination he feels, the social professional explains the roles and tools that are applied, but Ugo reiterates his point of view. Ugo suffered injustice because he would have at least had the right to rehearse; he thinks that the operators already knew whom to choose and that it is incorrect to tell him that he is not ready without testing him. The social and health professionals had a cultural and psychological explanation of his reactions.

4.3.5. Systemic Discriminations and Continuity of Care

These observations illustrate the misunderstandings and discrimination that vulnerable patients who are included in work integration procedures may feel. Unfortunately, complicit in this last case is the concomitance of a psychic discomfort; the person's reading of reality tends towards explanations of a persecutory nature. It is not an isolated case—the stress of the procedures and the kind of "purgatorial ceremonies" [33] in the field of assistance are not psychotic perceptions. In the case of psychological frailty, the pathogenic dimension of symbolic ceremonies is worsened. For Ugo, practitioners have long been working on getting him access to supportive psychological therapy—a difficult goal to achieve without a relationship of trust. This case again exemplifies the kind of vicious cycle and all the paradoxes faced by health and social workers and patients when vulnerability has bio-psycho-social dimensions.

The topic of adherence to the therapeutic plan or social planning in the field of integration is in these cases a unique issue for the person and poses the challenge of being addressed in a way that is not only coordinated but integrated. As Ridolfi points out,

the pursuit of health requires a methodological approach capable of bringing together knowledge from various disciplines and linking professionals from different fields [34].

5. Discussion on the Socio-Sanitary Cultural Mediation

5.1. Inclusive Communication and Efficacy in Healthcare

The issue of trust and relationships in an environment or time of life in which ties or orientations are precarious appears to be the only element of intervention effectiveness.

The ambivalent and/or conflicting communicative dynamics during health or social transitions, due to incomplete information or problems in the coordination between the actors of the network, trigger feelings of discrimination and prejudice in patients and operators. On one side, a vulnerable patient feels invisible because health and social professionals are concerned with the management of the disease or with educational and job planning. On the other side, social and health workers are faced with the paradox of health treatments that are not planned or not achievable due to the living environment or the timeframe of the integration phases. Finally, social integration objectives are not achievable due to the psychophysically compromised health situation. This phenomenon and the problem-solving approach typical of health and social services tend to focus more and more on diseases and integration projects. Within this approach, the difficulties of vulnerable patients are often “culturalized” and are not considered related to the context and situation of uncertainty that they are experiencing.

In health and social contexts, people ideally enter a vulnerable process with a biographical accident. Societies codify different steps of transition and give the person the possibility to find a new equilibrium and reintegrate a new identity.

Clinical vulnerability, applying an anthropological perspective on identity transitions, could be schematized as follows in Table 1:

Table 1. Clinical vulnerability scheme.

Context/ Transition Phases	First Phase of Assistance:	Second Step:	Ideal Conclusions:
Health condition: loss of health	Diagnosis process	Treatment	Incorporation/ Continuity of care
Social condition: loss of housing and work	Temporary collective housing	Housing + Job planning	Community integration

In a shelter situation, there is a kind of loop; a prolonged liminal phase of diagnosis blocks housing and job planning, and the freeze of housing and job planning then blocks the incorporation and continuity of care. In an apartment, a prolonged liminal phase of housing and job planning where people perceive “degradation ceremonies” [19] because of their ‘purgatorial’ character [32], instead of integration ceremonies impacts incorporation and continuity of care.

5.2. Cultural Informed Care

In the project, the ethnographic data and the anthropological analysis of patient trajectories have highlighted the need for a more culturally informed mediation between all the actors involved to improve the continuity of health and social care. This social and sanitary cultural mediation could act at different levels and also modify the setting and context of communicational events [35] to diminish this kind of double bind situation [36] which compromises both the integration and the therapeutic adherence of vulnerable patients. The double bind situation associated with the ‘purgatory rites and ceremonies’ during a so-called ‘integration process’ has an impact on physical and psychological wellbeing. A hypothesis that has been explored more is to evaluate this causality between integration procedures and mental illness in the field of marginalized ‘non-citizens’ [37]. The temporary character of the living context seems to be an important element to manage,

and a preventive socio-sanitary cultural mediation intervention could affect the interaction between patients and collective shelters and between the social and health professionals. As it has been pointed out, the ties and the relationship with the environment—social and material—are crucial for supporting the coping strategies of vulnerable patients. The socio-sanitary cultural mediation focuses primarily on the relational dimension of communication to improve continuity and co-construction of a common sense of the health and social situation instead of problem-solving in an emergency setting.

6. Conclusions

The extension of liminal phases caused by the lack of a cultural and symbolic ritualization of integration during social or health transitions has a pathogenic dimension. Moreover, the problem-solving approach inscribed in the assistance procedures produces a sort of “purgatorial rites” [33]. Health transitions and, in particular, the liminality phase of diagnosis, if unaccompanied and not correctly understood, can undermine the social resilience of patients because the patient rests in a phase of liminality. Social transitions, particularly the passage from collective shelters to their own apartment, is a sort of recognition of an accomplished degree of integration and people expect symbolic recognition of integration. When vulnerable patients experience the persistence of “purgatorial rites” in this phase, they return to a liminality phase that directly affects health, i.e., the experience and fear of “standing still” that vulnerable patients perceive to have a pathogenic effect on chronic illness. Culturally informed interventions of socio-sanitary cultural mediation could support these patients coping strategies.

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