Intercultural communication between doctors and patients; a multi-perspective exploration

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Contents

It all started on one of my first days as a doctor on the ward in a big teaching hospital. While communicating with a variety of patients, I experienced difficulties in communicating with patients with another cultural background than my own. Although I thought I had an open mind and an equally open attitude towards every patient, it was hard to satisfy the patients and myself in this context. In my opinion it was remarkable that the undergraduate training had not prepared me for the cultural diversity of the patients I met in the hospital. These experiences inspired me to investigate the topic and write this dissertation: intercultural communication between doctors and patients.

Chapter 1

General introduction

This dissertation is about the intercultural communication between Dutch doctors and non-native patients. The doctors are native medical specialists, who will be referred to as doctors. In the introduction, communication in the medical setting is explained. Furthermore, the introduction focuses on communication training in the medical setting and on the background of intercultural communication in particular.

Introduction into communication

Effective doctor-patient communication is generally acknowledged as a powerful diagnostic and therapeutic tool. Good communication is therefore a prerequisite for high quality healthcare. Good doctor-patient communication has shown to be effective in, amongst others, patient safety, reduction of prescriptions, medication adherence, clinical outcomes and patient satisfaction.[1]

In the days of Hippocrates, illness was studied within the context of individual patients as an idiosyncratic imbalance within an individual, resulting in complaints.[2] In the 19th century, the focus shifted from individual patients to diseases, as knowledge about pathogenesis increased. In the first half of the 20th century medicine mainly focussed on biological malfunctions which could be discovered from the description of symptoms, physical examinations and physical tests. In the second half of the 20th century, a more holistic model came to the forefront, which also acknowledged the psychological and social aetiologies and consequences of illness.[3] This implied a considerable evolution in doctor-patient communication, which is described by Silverman. In his book, Silverman defined the components of communication as the content of communication (what is communicated), the process of communication (how is it communicated) and the self-awareness during communication (what is thought and felt in the conversation).[4] This approach is used for practice and training in communication skills.

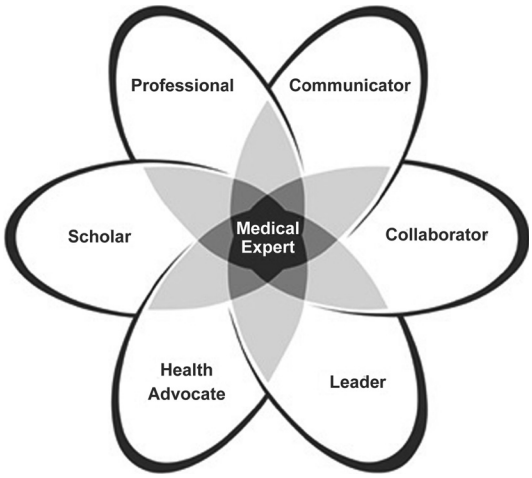
Communication training in medical curricula

Nowadays medical education is based on competency training (figure 1).[5] Communication is regarded as one of the core competencies of a good doctor.[6-8] In both undergraduate and postgraduate medical education, communication is one of the competencies which should be assessed.[9] It seems to be difficult to assess communication and a skill-based toolbox has been found insufficient. It has been revealed that there is no recipe for good communication.[10] Although lots of efforts have been made in countries all over the world, communication training is often limited in time, not inte-

grated in the curriculum and scarcely contextualised.[11,12] Also, research showed that communication skills that were acquired during undergraduate medical education are transferred sparsely into real practice.[13]

One of the reasons for the inadequate transfer of communication skills could be that communication skills training is an ongoing process and should be integrated in post-graduate medical education as well. Besides, acquiring communication skills entails several stages for which acting in real practice is required. The stages of effective change of communication behaviour were investigated by Van den Eertwegh et al. and were found to be based on confrontation, reflection and raising self-awareness.[14] Every healthcare professional needs to master core skills to be able to overcome specific communication challenges, such as cultural issues.[11] Therefore, communication training in medical education remains a topic for discussion and further exploration.

Figure 1. CanMEDS flower of core competenties of doctors.[5]



Context of communication

Attention to the communication behaviour of doctors is increasing, especially since doctors need to apply effective communication in various contexts. The word context is used in different ways. Context can be assumed to be a real place, for example the consultation room itself, but it can also be conceived as a characteristic, for example the background of a patient during a conversation. Context can give meaning to a message and it supports the effect a message has on the other person. Several

contextual factors seem to influence doctor-patient communication.[15] However, doctors are not always aware of the influence of context on communication.[16] Context factors should be considered in communication teaching and communication assessment.[15,17] One of the contexts in which doctor-patient communication takes place is the situation of an intercultural context, which is the focus of this dissertation.

Intercultural communication in healthcare

Due to growing global mobility, migration and international teamwork, attention to intercultural communication is of major significance for healthcare. In the context of this dissertation, the term culture should be explained first. Culture could be seen as the glasses through which we see the world. It includes how we interpret this world and how this is valued by ourselves.[18] The cultural background of the communicators plays a major role in the process of communication, because of different habits, values, expectations, and perceptions.[19,20] A cultural difference could result in, for example, a lack of trust of patients.[21] Cultural differences are described in explanatory models of illness and disease, cultural values, preferences for doctor-patient relationships, racism, bias and language barriers.[22] The culture of a person is not equal to this person's ethnicity. Differences between ethnic groups are for example, language, history of migration, health literacy and stereotyping.[18]

The importance of intercultural communication has been recognised since missionaries, merchants and researchers met people from different cultures and experienced differences in communication behaviour. However, intercultural communication as a research area has a short history of about 50 years and has interfaces with anthropology, sociology, psychology and medicine. In this dissertation, intercultural communication is defined as follows: the process of interpersonal interaction between ethnic different doctors and patients. The doctors included in the studies of this dissertation are Dutch (native) and the patients are non-Dutch (non-natives) (table 1).

Knowledge about other cultures alone is not enough to generate effective intercultural communicators.[4] General communication behaviour and attitudes are also indicated as necessary for effective intercultural communication, and doctors struggle with applying this communication behaviour in an intercultural context.[4] The misconception is that it is best to focus on what both parties have in common. To interact effectively, it is necessary to focus much more on the other party than in the case of interacting with people who share the same cultural routines. Besides, it is necessary to be aware of one's own role, behaviours and assumptions in a conversation,

because reflection on one's own behaviour facilitates an open conversation.[20]

Doctor-patient contacts within a multicultural context potentially result in misunderstandings and low quality communication, which may reduce the quality of care.[23-25] Evidence suggests that ethnic minority patients in developed countries visit the doctor more often[26] and have longer visits[27] but are less satisfied with the doctor-patient contact.[24,28] On the other hand, doctors feel insecure when interacting with patients from a different ethnic background.[29,30] Although doctors say that they are aware of the cultural differences, they still feel incapable of interacting socially and emotionally with patients from different ethnic backgrounds.[31] All this underscores the need for research in the area of intercultural communication in healthcare.

Intercultural communication in medical education

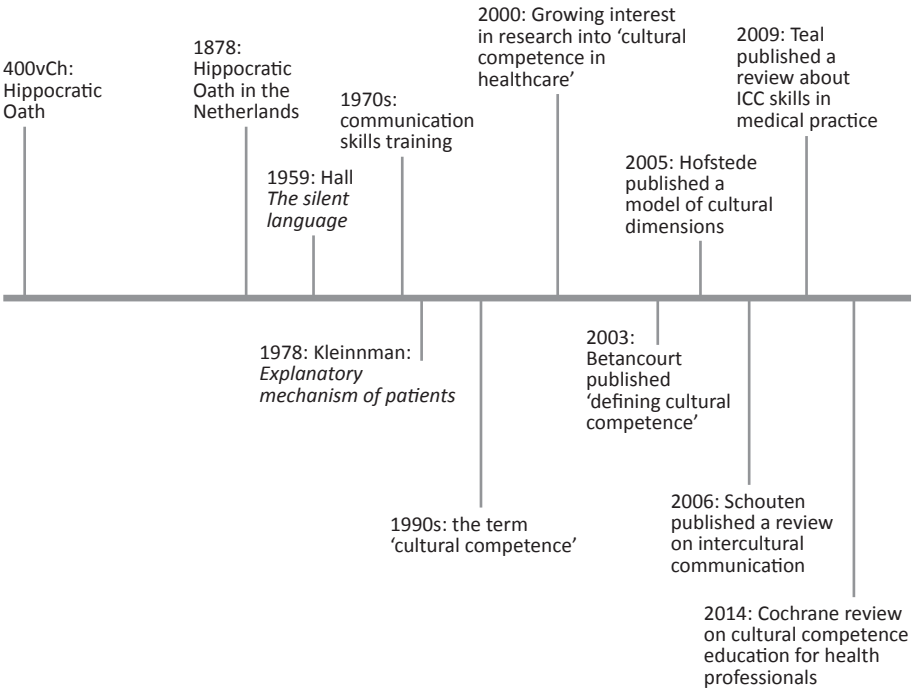
Since the global migration of the 1960s, intercultural communication has become a topic of growing interest in medical science (figure 2). The amount of scientific research on the topic has vastly increased during the last 20 years.[32] In most of these studies, intercultural communication was seen as a component of cultural competence.[33] However, cultural competence training has not been structurally implemented in medical education.[25,34,35] A recent review on cultural competence education for health professionals concluded that more research is needed to reach consensus on the core components of cultural competence education.[36]

Although the need for cultural competence is well accepted in many Western countries, there is no consensus on the most effective method for achieving the right balance between attitudes, knowledge and skills.[37] Practical frameworks were therefore developed[38,39], which transformed the general requirements into measurable clinical terms, such as knowledge of epidemiology, the different effects of treatment in various ethnic groups, awareness of how culture shapes individual behaviour, social contexts and one's own prejudices, skills to transfer information and to adapt one's communication skills to new situations.[39,40]

Earlier research on intercultural communication training in medical education focussed on the challenges in communication, which were translated into competencies. For example, Teal et al.[38] developed a model which enables an empathic, mindful, and reflective doctor to engage with members of diverse populations. The model is composed of four critical elements of culturally competent communication in the medical encounter. These elements are communication repertoire, situational awareness, adaptability, and knowledge about core cultural issues. This model em-

phasises the incremental development of communication skills for managing the cross-cultural nature of the clinical encounter, and is offered as one step further toward understanding intercultural communication.[38] Studies underscore the need for more qualitative research on intercultural communication to generate more insights into the gaps of intercultural communication[22] and to facilitate the application of intercultural communication skills in actual practice.[36,41]

Figure 2. Timeline based on relevant literature for this dissertation.



Ethnic variations in the Netherlands

The research in this dissertation is situated in the Netherlands, a country with 17 million inhabitants. In 2014, this population comprised 3.5 million (20%) non-native citizens with over 200 nationalities.[42]

The Netherlands is a country with a long history of cultural diversity. Migration to the Netherlands started in the 17th century, and during the 1960's the Netherlands experienced an increase in immigration because of the country's growing prosperity, which attracted numerous immigrants who were searching for work.[43] Ethnic groups

in the Netherlands are roughly divided into Western and non-Western groups. The largest non-Western groups originate from Morocco and Turkey. The Western groups are categorised as originating from Europe, North-America, Canada, Australia and New-Zealand.[42]

The setting of this dissertation

The studies of this dissertation were conducted in a district teaching hospital (OLVG) in Amsterdam, the Netherlands. The population of patients who visit this hospital consist of around 70 nationalities. The OLVG pays specific attention to cultural diversity among its patients and employees. It is therefore recognised by the European Commission as a 'migrant-friendly' hospital, an international hallmark based on the framework of the WHO Network on Health Promoting Hospitals.[44] For this dissertation, this means that employees and the organisational board of the hospital can be expected to have more experience and be more aware of the effects of cultural differences between the doctor and the patient than on average.

In this dissertation we distinguish two groups of patients: native Dutch patients and non-native patients. Native Dutch patients are those who were born in the Netherlands and whose parents were also born in the Netherlands. Non-native patients are those who were either born outside the Netherlands themselves or who have one or two parents who were born outside the Netherlands.

The perspective of this dissertation

This dissertation reflects in a qualitative way on intercultural communication in the medical encounter, adopting a constructivist perspective. The latter means that reality and knowledge are viewed as constructs that result from interactions between people. This suggests that multiple truths exist, and that these are dependent on the perceptions of people in a specific context.[45-47] While the constructivist lens serves as an overarching theoretical perspective in this dissertation, the dissertation is not methodologically confined to this approach.

The scope of this dissertation

The focus of this dissertation lies on postgraduate training and on medical specialists, because the latter function as a role model for postgraduate medical trainees and train the residents. This implies that medical specialists are skilled communicators.[48] Each chapter of this dissertation deconstructs a different element of inter-

cultural communication, aiming to enrich the understanding of its complexity and of the different perspectives involved and to illuminate how the topic intercultural communication is imbedded in medical education. Together, the chapters form a stepwise – though not exhaustive – exploration of how intercultural communication is experienced and applied in clinical practice. The research questions (RQ) for this dissertation are:

RQ1: What kind of intercultural communication training in medical education is offered in the written curricula of undergraduate and postgraduate education?

RQ2: What are important factors in communication with non-native patients and which skills do doctors need to apply to practice effective intercultural communication?

RQ3: Which intercultural communication skills do doctors currently apply in clinical consultations?

RQ4: How do doctors and patients perceive intercultural communication in a clinical setting and how does this influence their communication?

Objective and outline of this dissertation

The first objective of this dissertation is to create a multi-perspective view on intercultural communication between doctors and patients based on insights of literature, doctors, patients and observers. Therefore, the aim was to explore intercultural communication in the medical encounter in several ways and to formulate recommendations for intercultural communication training in medical education curricula. The structure of this dissertation is displayed in figure 3.

The second objective was to give insights into the gap between communication training offered in medical education and the requirements of intercultural communication in clinical practice, and into the gap between research regarding intercultural communication and clinical practice. For this, it was important to explore the current status of intercultural communication in medical education.

The first aim of this dissertation was to evaluate the content and educational aspects of cultural diversity training described in curriculum documents (**chapter 2**). To this end, the curriculum documents of undergraduate and postgraduate medical education were analysed. This provided a starting point for studying intercultural communication in the medical setting.

The second aim was to expand the knowledge on intercultural communication in clinical practice. In order to provide an overview of the existing literature regarding

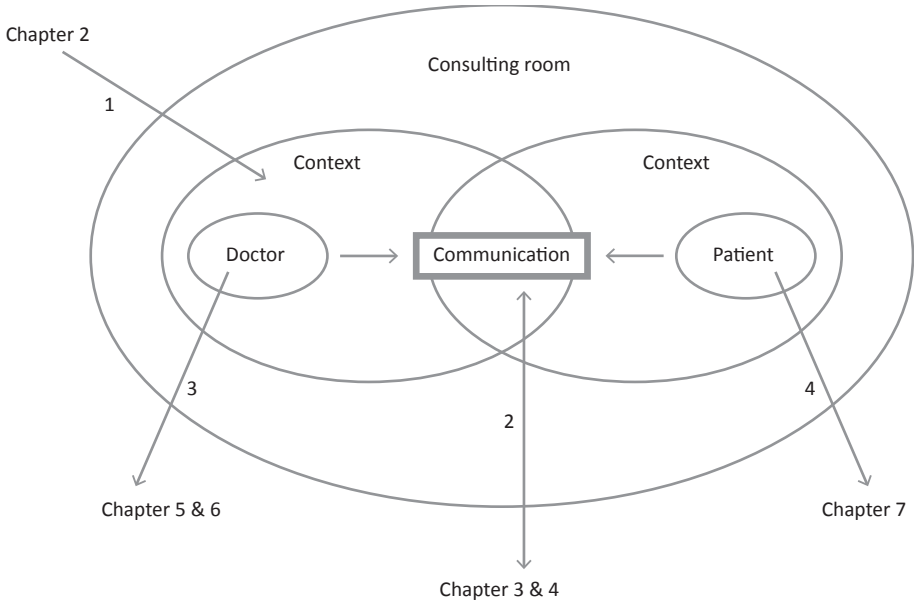
intercultural communication between doctors and patients, a systematic literature review was performed, which is presented in **chapter 3**. Intercultural communication mechanisms were explored, as were barriers and facilitators of effective intercultural communication. The method used to answer this question was a realist review, which seeks to unravel the mechanisms of a specific process. This review revealed several aspects of intercultural communication, resulting in the conceptual framework of this dissertation. **Chapter 4** presents a reflection on the applied realist review method. Since this method is an approach that has been used extensively for social research but is a relatively new in medical education research, challenges regarding the use of this method were experienced. In this eye opener manuscript an overview of the pitfalls and our experiences performing a realist review are presented.

The third aim was to explore how elements that were discovered by means of the realist review were relevant in clinical practice. To this end, an observational study was conducted (**chapter 5**) using videotaped doctor-patient consultations at various outpatient departments of a teaching hospital in Amsterdam. For this study medical specialists were included of the outpatient departments of gynaecology, urology, orthopaedic surgery and internal medicine. The analyses focussed on relevant intercultural communication skills of these medical specialists in the context of an intercultural conversation.

Chapter 6 and 7 describe what patients and doctors consider relevant in intercultural communication. This is the fourth aim of this dissertation. We reflected with doctors (**chapter 6)** and non-native patients (**chapter 7)** on relevant intercultural communication which doctors should apply.

In **chapter 8** the results of the previous chapters are discussed in depth, including recommendations and implications for future research.

Figure 3. Overview of the focus areas in this dissertation*.



*Arrow 1: doctor receives training; arrow 2: how intercultural communication works; arrow 3: observation of doctors' communication skills and doctors' views; arrow 4: patient preferences and experiences.

Table 1. Terminology used in this dissertation.

Term	Operationalisation in this dissertation
Culture	Culture is a socially transmitted pattern of shared meanings by which people communicate, perpetuate and develop their knowledge and attitudes about life.[49] 'The glasses through which one sees the world.'[18]
Ethnic background	The fact or state of belonging to a social group that has a common national or cultural tradition. In the Netherlands this is based on the place of birth of a person or his or her parents.
Different ethnic background (non-native)	Born in a country different than the person one is communicating with, or having a parent who was born in another country.
Cultural competence	The knowledge, attitudes and skills necessary to provide good quality of care for ethnic minority patients.[33]
Intercultural communication	A part of cultural competence, communication between native and non-native persons, persons who differ in ethnic backgrounds. (this dissertation)
Cultural diversity	The variety of ethnic or cultural backgrounds of people living in a society.[36]
Intercultural sensitivity	The degree to which one is actively interested in other people's cultural backgrounds, their needs and perspectives.[20]

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Chapter 2

Cultural diversity: blind spot in medical curriculum documents, a document analysis

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BMC Med Educ, 2014,4:176

Abstract

Background

Cultural diversity among patients presents specific challenges to physicians. Therefore, cultural diversity training is needed in medical education. In cases where strategic curriculum documents form the basis of medical training it is expected that the topic of cultural diversity is included in these documents, especially if these have been recently updated. The aim of this study was to assess the current formal status of cultural diversity training in the Netherlands, which is a multi-ethnic country with recently updated medical curriculum documents.

Methods

In February and March 2013, a document analysis was performed of strategic curriculum documents for undergraduate and postgraduate medical education in the Netherlands. All text phrases that referred to cultural diversity were extracted from these documents. Subsequently, these phrases were sorted into objectives, training methods or evaluation tools to assess how they contributed to adequate curriculum design.

Results

Of a total of 52 documents, 33 documents contained phrases with information about cultural diversity training. Cultural diversity aspects were more prominently described in the curriculum documents for undergraduate education than in those for postgraduate education. The most specific information about cultural diversity was found in the blueprint for undergraduate medical education. In the postgraduate curriculum documents, attention to cultural diversity differed among specialties and was mainly superficial.

Conclusions

Cultural diversity is an underrepresented topic in the Dutch documents that form the basis for actual medical training, although the documents have been updated recently. Attention to the topic is thus unwarranted. This situation does not fit the demand of a multi-ethnic society for doctors with cultural diversity competencies. Multi-ethnic countries should be critical on the content of the bases for their medical educational curricula.

Background

In multi-ethnic societies, providing effective healthcare is challenged by various aspects of cultural diversity, such as epidemiological health differences between populations, communication barriers and differences in religion, socio-economic status and ethnic background.[1] During the past decade, various studies have demonstrated that the increase in cultural diversity in many patient populations presents specific challenges to healthcare providers.[2,3] For instance, ethnic minority patients in developed countries, visit the physician more often[4], have longer visits[3] and are less satisfied with the physician-patient contact.[5-7] In addition, language barriers have been shown to diminish healthcare outcomes[6], and some ethnic groups have prolonged hospital stays and more unplanned re-admissions.[3]

To provide good quality of care, physicians need to be able to acknowledge, recognise and deal with these challenges. Therefore, cultural diversity should be addressed in medical training.[8-12] In multi-ethnic countries, cultural diversity is considered an essential topic in society[8,11,13], which needs to get attention in medical training to prepare students for their work as physicians.[13]

To ensure adequate attention to cultural diversity, cultural diversity training should be anchored in strategic curriculum documents for medical education in multi-ethnic countries. Ten to 15 years ago, overviews of curricula of medical education in the United States of America (USA), Canada, the United Kingdom (UK) and the Netherlands showed that cultural diversity training was scarcely addressed and that students' preparation for cultural issues was inadequate.[1,9,14] Since then, however, cultural diversity in medical education has been identified as a point of interest in the Netherlands, as in many other Western countries.[2,9,14,15] Also, in recent years, there have been several occasions for revising the content of programs and for including cultural diversity in the curriculum documents. For example, in the Netherlands, the training programs for undergraduates were recently inspected and the curriculum documents for postgraduates were recently revised.[16]

Since cultural diversity training is considered essential for physicians[8,11,12], it is important to know if cultural diversity has gained more attention in curriculum documents over the last years. Insight into the current status of cultural diversity in strategic curriculum documents is required to assess whether the conditions for effective curriculum development in this area are met.

The aim of this study was to assess the formal status of cultural diversity training in a multi-ethnic country. In particular, we studied the formal status of cultural diversity

training in the Netherlands, a country with 17 million inhabitants, 3.5 million (20%) of whom are members of ethnic minority groups.[17] Although not composed of various ethnic groups since its foundation, the Netherlands has been a diverse country for a long time. Migration to the Netherlands started in the 17th century and after that the Netherlands experienced a growing migration since the 1960's because of its growing prosperity and the following migration for work.[18] This ethnic diversity currently ranges from a Moroccan population to Turkish, Surinamese and Western migrants.[17] We conducted a document analysis focusing on the current attention to the topic of cultural diversity training in strategic curriculum documents that form the basis of actual training. The question that guided our research was: to what extent and how is attention to cultural diversity ensured in the strategic curriculum documents that guide medical education in the Netherlands?

Methods

Setting

We conducted this study on curriculum documents of the Netherlands, as a case of a country with a culturally diverse patient population and recently revised curriculum documents for medical education. Medical education in the Netherlands consists of undergraduate and postgraduate medical education (UGME and PGME). Undergraduate education is provided by all 8 universities in the country, which all have an university teaching hospital. Postgraduate specialty education is executed in eight regions of which each contains one of the university teaching hospitals and several affiliated general teaching hospitals. Actual training is executed in the hospitals, which is referred to as "locally". Both UGME and PGME are directed by national and regional curriculum documents. These are all policy documents and serve as guidelines for the taught curriculum. The documents describe the requirements and goals which should be fulfilled at the end of the training, using the roles described by the Canadian Medical Education Directives for Specialists (CanMEDS).[19] The national documents are developed by project groups of concerned stakeholders which are coordinated by the national organisation Royal Dutch Medical Association.[20] This organisation insists on the quality of medical profession and healthcare. For undergraduate medical education (see figure 1), the national document is the blueprint. The blueprint was introduced in 1994 and rewritten in 2009 to define student's learning outcomes. For postgraduate medical education (see figure 2) national curriculum documents are concentrated to specific specialty training. Some specialty training

does not have a national curriculum document, because some training is only given in one region. In these cases, we used regional documents.

For undergraduate medical education only describing the blueprint could be too superficial, because of its intended nature to only function as a guideline. Therefore, we decided to include the accreditation reports of the 8 universities in the Netherlands as well. This accreditation is done for every university separately by a commission of external experts, which checks if the rules of the blueprint are followed. This is done every four years or more frequently if the commission decides so.[21] These documents could be seen as regional documents. We included these documents to gain a deeper insight into the point of interest and improvements of every university.

Figure 1. The used curriculum documents for undergraduate medical education in the Netherlands.

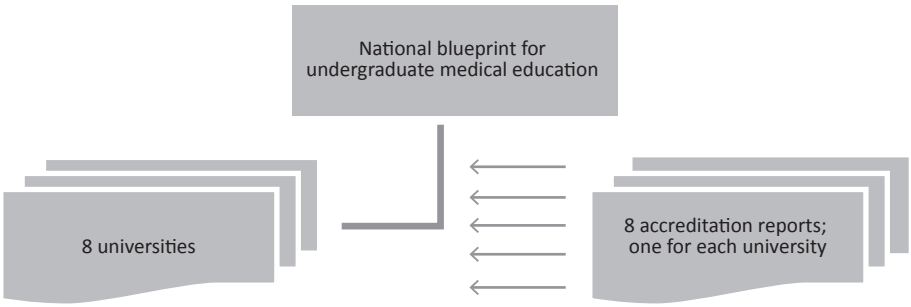
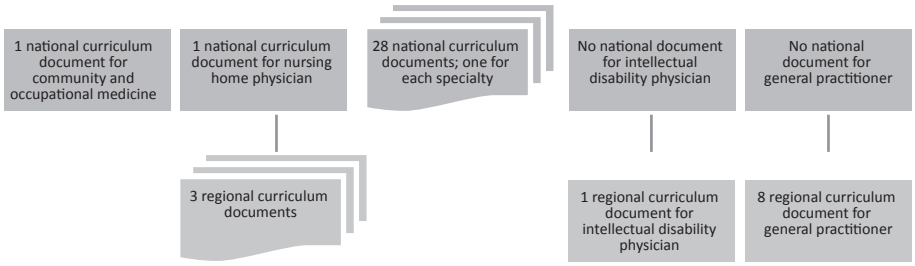


Figure 2. The used curriculum documents for postgraduate medical education in the Netherlands.



Design

To describe the formal status of cultural diversity training, we performed a document analysis of the UGME and PGME curriculum documents. As a basis, we used the

educational framework of the Accreditation Council for Graduate Medical Education (ACGME)[19], which focuses on three domains: objectives, methods and evaluation. Objectives are the competencies (knowledge, skills and professional behaviour) that have to be acquired by the trainees. The training methods explain how these competencies should be attained, and evaluation indicates how achievement of the objectives should be examined. The three domains are generally presented in this systematic order[19], and their inclusion can be considered a requirement for adequate curriculum design[22]. For example, a competence described in the curriculum document of the postgraduate training for gynaecologist is *'the support of a physiological delivery'*. The objective for this competence is that residents demonstrate to support an uncomplicated delivery without supervision. The training method used is the exercise on the phantom, and the final evaluation consists of practical exam on the phantom.

Procedure

The strategic curriculum documents were retrieved through internet searches in February and March 2013. Documents that were not available on the internet were requested from program directors by email.[20,21,23] On the advice of program directors of the undergraduate medical education, we also retrieved the national blueprint (a national policy document for medical undergraduate education)[24] and the accreditation reports that Quality Assurance Netherlands Universities (QANU) made of the 8 universities that provide a medical curriculum. The accreditation reports of medical education contained evaluations of all the bachelor and master programs.[21] One university's undergraduate accreditation report was not available at the moment of analysing the data. Instead, this university provided a summary of the cultural diversity objectives mentioned in their accreditation report. For the purpose of this study, cultural diversity was defined as a difference in ethnic background between a physician and his or her patient.[25]

Analysis

The first author (EP) systematically read the strategic curriculum documents and extracted all phrases about cultural diversity. Text phrases of the documents which mentioned cultural diversity (i.e. diversity, cultural, intercultural, ethnicity) were sorted into the three domains of the ACGME framework, objective, method and evaluation.[19] To interpret the meaning of the extracted phrases about cultural diversity, this was an iterative process.[26] Doubts concerning the inclusion of text phrases and their

position in the framework were discussed with co-authors JF and KL. There was disagreement about three phrases, which all concerned mini-CEX. After discussion with all members of the research team whether these should be considered methods or evaluation tools three phrases were changed from evaluation tools into methods.

Results

In total, 52 documents were analysed. For undergraduate education, we analysed one national document, 7 regional curriculum accreditation reports and one summary. For postgraduate education, we analysed 31 national curriculum documents and 12 regional curriculum documents. Text phrases about cultural diversity were found in 33 of these documents. In 6 of these, a specific text referred to cultural diversity. In 2 out of 52 documents, cultural diversity was referred to in all three domains, objective, training method and evaluation, and in the appropriate sequence. A summary of the findings is presented in table 1.

Table 1. Summary of number of documents with text phrases regarding cultural diversity training.

Training	Total documents (nat/reg *)	In *n* documents phrases of cultural diversity			
		Objectives (O)	Methods (M)	Evaluation (E)	Combination (O+M+E) †
Undergraduate training, national	1 (nat)	1	0	1	0
Undergraduate training, accreditation	8 (reg)	0	0	0	0
Graduate training: community and occupational medicine	2 (nat)	1	0	0	0
Graduate training: nursing home physician	4 (1 nat/3 reg)	4	0	0	0
Graduate training: general practitioner	8 (reg)	1	1	0	0
Graduate training: intellectual disability physician	1 (reg)	1	0	0	0
Graduate training: clinical residency training	28 (nat)	17	5	2	2

* national/regional

† In *n* documents a combination of objective, methods and evaluation was mentioned in one sequence.

Cultural diversity in curriculum documents for undergraduate education

The Dutch national blueprint for undergraduate medical education was found to contain several objectives regarding cultural diversity. These objectives are formulated within the CanMEDS roles of Communicator, Medical expert and Health advocate. For example, in the description of the role Communicator, cultural diversity is specified as *"The student adequately handles diverse groups of patients, such as children, elderly, men, women and patients from different cultural backgrounds"*.

Attention to training methods was not found in the blueprint. It contained the recommendation that requirements, which should be fulfilled at the end of the programs, should be realistic and trainable, but no description is given of training methods. Regarding evaluation, it contained an appendix with a skills list that takes cultural aspects into account (evaluation). For example, *"Does the student indicate the influence of ethnic diversity on the healthcare process?"*

Compared to the national blueprint, fewer references were found in the accreditation reports. Of 7 regional accreditation reports and 1 summary of an accreditation report on undergraduate training, 3 did not mention cultural diversity, whereas 5 did address themes concerning cultural diversity. The cultural diversity themes described in these 5 documents were 'learning medical ethics and diversity management', 'acquiring cultural competence', 'offering obligatory education about cultural diversity' and 'global health training'. Three of these 5 documents contained a small section that defined the term 'cultural competence'.

Cultural diversity in curriculum documents for postgraduate education

General practitioner

Two out of 8 regional strategic curriculum documents for the specialty 'general practitioner' contained a description of cultural diversity themes. One of these described the *"changing population's demands on care"*, but this objective was not followed by a description of methods or evaluation. The other document contained a training method description referring to an elective course on multicultural care, which was not followed by an evaluation nor preceded by objectives. The other 6 documents contained no reference to cultural diversity training.

Community and occupational medicine

The national curriculum document on the specialty of community and occupational medicine is split into two documents, a manual and a curriculum. One of these, the

manual, cultural diversity was addressed. This description was placed among the objectives, as part of the role of Communicator. It was not followed by a description of a training method or an evaluation.

Nursing home physician

There are 4 national and regional strategic curriculum documents for the specialty 'nursing home physician', all of which offered a description of the role of Communicator in the context of a different cultural background of the patient (objective). These documents contained no phrases concerning methods or evaluation of cultural diversity training.

Intellectual disability physician

The regional strategic curriculum document for the specialty 'disability medicine' mentioned one CanMEDS role in the context of cultural diversity training; the role of Health advocate. This was followed by a brief reference to training method, *"The student integrates development and implementation of general medical insights with population-specific characteristics"*, without any reference to evaluation.

Clinical residency trainings

Ten out of 28 curriculum documents for clinical residency training did not mention cultural diversity. Cultural diversity was mentioned in 18 of the 28 documents on clinical residency training. In 17 of these 18 documents, cultural diversity objectives were described. These were formulated within various roles: Collaborator, Professional, Medical expert, Communicator, Health advocate or Reflector, which is a newly coined role. In 4 documents the objective was followed by a method, and in 2 of these, psychiatry and emergency medicine, the objective and method were followed by an evaluation. The training methods were the Mini-Clinical Evaluation Exercise (Mini-CEX) and *"The student should see a diverse patient population".* The evaluation consisted of observing the student in the context of cultural diversity, and of considering: *"Does the student recognise culture-specific presentations?"*

One of the 18 documents only described a method *("The student should see a diverse patient population"*), which was not preceded by an objective nor followed by an evaluation. In 2 of the 18 documents, cultural competence was generally mentioned as necessary for a physician.

Discussion

This document analysis provided an impression of the formal status of cultural diversity in medical education in a multi ethnic country. We discovered that only half of all strategic curriculum documents contained references to cultural diversity training. Cultural diversity aspects were more prominently described in the curriculum documents for UGME than in those for PGME. The most specific information about cultural diversity was found in the blueprint for UGME. In the postgraduate curriculum documents, attention to cultural diversity differed among specialties and was mainly superficial. We found a remarkable absence of a systematic sequence of training objectives, training methods and evaluation, while this is regarded as important for adequate curriculum design.[19]

Our finding of the amount of attention to cultural diversity resemble the results of the studies of Dogra et al. and Lu et al., who also described a remarkable absence of clearly described content for cultural diversity training in other countries.[27,28] They suggested that explanations for the missing content could be the challenges for the construction of a curriculum in ethnically diverse countries[14,15,27] and lack of universal core contents and standards. Another reason might be competition in an overloaded curriculum.[28] Furthermore, there is no clear consensus about the content that ought to be included in a cultural competence curriculum for physicians.[29] Still, there are also many initiatives worldwide to raise awareness for cultural competence in medical education for healthcare workers, national[30-32] and local.[33] In the USA for example, a strategy to incorporate cultural competence into training programs was developed.[30] Other examples are the UK[34] and Canada[35] where cultural diversity training for doctors is initiated.

One of the strengths of our study was that it was performed in a country with recently modernised curricula, which could be assumed to be updated according to recent insights into the requirements of a multi-cultural patient population. Our findings can serve as a basis for further research on the actual frequency and quality of cultural diversity training in medical education in newly ethnic diverse countries. A limitation of the study is that documents do not need to reflect the actual frequency and quality of cultural diversity training in educational practice, since the documents often contain abstract formulations. On the other hand, the fact that cultural diversity is mentioned in the curriculum documents does not ensure that attention is given to this subject in actual practice.

In conclusion, the importance of cultural diversity training has become apparent in

Dutch undergraduate curriculum documents over the past ten years, although the vague and abstract terms used in these documents still need to be translated into practical guidelines for curriculum design. In postgraduate curriculum documents, there is little to no evidence that recent innovations in the Dutch medical curriculum have improved attention to cultural diversity training, even though it is widely acknowledged to be necessary for all physicians who wish to deliver the highest quality of care. Thus, despite public recognition that cultural diversity competencies are important for doctors in a multi-ethnic society, this recognition alone has not been sufficient to ensure adequate attention to cultural diversity training in medical curricula of newly diverse countries. This study could help to raise awareness among curriculum designers and could give leads for the development of a cultural competent curriculum.

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Chapter 3

Factors influencing intercultural doctor-patient communication: a realist review

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Abstract

Objective

Due to migration, doctors see patients from different ethnic backgrounds. This causes challenges for the communication. To develop training programs for doctors in intercultural communication (ICC), it is important to know which barriers and facilitators determine the quality of ICC. This study aimed to provide an overview of the literature and to explore how ICC works.

Methods

A systematic search was performed to find literature published before October 2012. The search terms used were cultural, communication, healthcare worker. A realist synthesis allowed us to use an explanatory focus to understand the interplay of communication.

Results

In total, 145 articles met the inclusion criteria. We found ICC challenges due to language, cultural and social differences, and doctors' assumptions. The mechanisms were described as factors influencing the process of ICC and divided into objectives, core skills and specific skills. The results were synthesised in a framework for the development of training.

Conclusion

The quality of ICC is influenced by the context and by the mechanisms. These mechanisms translate into practical points for training, which seem to have similarities with patient-centred communication.

Implications for practice

Training for improving ICC can be developed as an extension of the existing training for patient-centred communication.

Introduction

Due to increasing worldwide migration since the 1960's, healthcare in the modern Western world is confronted with the consequences of a multi-ethnic society.[1] One of the main areas where these consequences are apparent is in the interaction between doctors and patients. As research on communication in healthcare has shown, there is ample evidence that communication affects numerous outcomes, such as patient satisfaction and adherence, and, consequently, health outcomes.[2,3] One of the challenging areas of healthcare communication is communication with culturally diverse patients.[4] Intercultural doctor-patient contacts are potential sources of misunderstanding and low quality communication, which may reduce the quality of care.[5]

Causes for misunderstanding and difficulties in intercultural communication (ICC) are sought in differences in perspectives, values and beliefs about illness between doctors and patients with different ethnic backgrounds.[6-9] Illness is culturally determined in the sense that how we perceive, experience and cope with disease is based upon our explanations of illness.[7] Hence, difficulties in intercultural doctor-patient communication could be explained by differences in culture rather than by a supposed inferiority of specific cultures.[8] Another possible influence on the quality of patient communication is that many doctors feel incompetent to communicate and relate to patients from different ethnic backgrounds due to a lack of adequate skills, language barriers or knowledge of communication with these patients.[10,11] For example, doctors behave less effectively when interacting with ethnic minority patients compared to ethnic majority patients.[5,12] Also, ethnic minority patients themselves are less verbally expressive and seem to be less assertive during the medical encounter than ethnic majority patients.[12]

In recent years, medical education has paid more attention to ICC, or to cultural competence on a broader scale (see table 1 for terminology). Although the necessity of training in ICC has been increasingly recognised[13], many countries with a multi-ethnic patient population have not structurally implemented training in this area in their medical curricula[14,15], even though there is a flourishing debate about appropriate training of health professionals to respond to ethnic diversity.[16,17] Next to the difficulties of implementing ICC in medical curricula, assessment of ICC remains challenging[18], and there is a risk that ICC and cultural competence training reinforce stereotyping.[19] The challenge, therefore, is to achieve a balance between theory and practice. Developing an appreciation of theoretical concepts of ICC is desirable for

'generic learning'. However, such learning would fail without emphasising its relevance to practice.[16]

The field of ICC in healthcare has been studied extensively. For example, Schouten et al. performed a systematic review in this field to gain more insight into the effects of ethnic background on the medical communication process.[12] Although their research was substantial, it was limited by including observational studies only. The authors concluded that there are differences in the communication with ethnic minority patients compared to ethnic majority patients, and they advised to focus further research on explanatory factors to advance knowledge about the origins of and solutions for problems in ICC.[12]

Several studies recommended an exploratory review to reveal what factors influence the outcome of ICC[20], but as far as we know, such a review is still lacking. A systematic description of the influencing factors in ICC may inform the development and implementation of training and education for doctors, which could provide opportunities to facilitate communication of better quality.[1,21] Also, such research could give insight into the link between patient-centred communication and ICC, which was mentioned in several papers.[13,17]

The present paper provides an overview of the literature on the perceptions and experiences of doctors and patients related to communication in an intercultural setting. Although ICC can include many contexts, we focussed on the largest and perhaps most challenging group of intercultural encounters, i.e. those between doctors of the ethnic majority and their patients of the ethnic minority (see table 1 for the used definition of ICC). Our research was guided by the following questions: Which factors influence the communication process between doctors and patients of different ethnic backgrounds? How do these factors influence the communication?

To apply the intended exploratory focus, we performed a realist synthesis, which could help us to gain insight into the complexity of communication between doctors and patients.[22] We tried to formulate a framework for medical education, which could be used for the development of ICC training for doctors. Our main focus was not on the misunderstandings, but on the broader concept of intercultural communication.

Table 1. Explanation of the used terminology.

Terminology*	Explanation
Culture	Culture is a socially transmitted pattern of shared meanings by which people communicate, perpetuate and develop their knowledge and attitudes about life. An individual's cultural identity may be based on heritage as well as individual circumstances and personal choice and is a dynamic entity.[23]
Ethno-cultural diversity	The diversity of people with different ethnic cultural and linguistic backgrounds.[24]
Ethnic background	The fact or state of belonging to a social group that has a common national or cultural tradition: 'the interrelationship between gender, ethnicity, and class'.[25]
Cultural competence	Knowledge, attitudes and skills required to provide good quality care to ethnically diverse patient populations.[26]
Intercultural communication	Communication between doctors and patients with different ethnic backgrounds; a part of cultural competence.[26,27]
Cross-cultural communication	Comparison of communication across cultures.[27]
Intercultural communication competence	The degree to which we actively monitor how we communicate with people from other ethnic cultures.[28]
Culturally competent communication	Communication repertoire, situational awareness, adaptability and knowledge about core cultural issues.[9]
Intercultural sensitivity	The degree to which we are actively interested in other people's cultural backgrounds, their needs and perspectives.[28]

* This table explains the terminology used in our research. We are aware that this is one of the many operationalisation's for these terms.

Methods

We conducted a systematic review of the literature using the realist synthesis method guided by the RAMESES guideline, a realist review guideline.[22] A realist review is a strategy for synthesising research that has an explanatory rather than a judgmental focus. It can include qualitative as well as quantitative studies, which enables us to focus on the content, i.e. meaningful and useful results, of the articles. The adjective realist refers to the philosophy of science called realism, which is situated between positivism, i.e. the conviction that there is a real world and that we can apprehend this world directly through observation, and constructivism, i.e. the conviction that reality is a social construction and that we cannot know what the true nature of reality is.[29,30]

A realist synthesis emphasises how causal mechanisms are shaped and constrained by social context. The extracted data are described and explored using the model

of context (C), mechanism (M) and outcome (O). For example, to evaluate the ICC process (O), a realist synthesis would examine its underlying mechanisms (e.g. the way a doctor behaves in a conversation), and its contiguous contexts (e.g. a language barrier between the doctor and the patient).[22,30]

Data sources and searches

Literature searches were performed by an experienced information specialist, who searched MEDLINE, EMBASE, PsycInfo, Cinahl, Cochrane and Education Resources Information Center (ERIC) for relevant papers using Reference Manager 12. All studies published before October 2012 were included. No language restrictions were applied, and papers were translated if necessary. However, articles without English abstract were excluded, as were letters, reviews, comments, case reports, books, and editorials.

Databases were searched using keywords for both free text (tiab) and Medical Subject Heading (MeSH) terms. A combination of the following keywords and synonyms were used: *communication AND cultural AND ethnic AND healthcare worker*. The broad search terms were used to ensure that all studies which met the inclusion criteria were captured in initial searches. The search strategy for the main electronic search (MEDLINE) is presented in appendix A. It was revised as necessary for the other databases. (Full searches for these databases are available upon request.)

Data selection

Firstly, duplicates were identified and removed by the first author. Next, the titles of the articles were screened for inclusion by the first author (EP) and a group of seven second readers. Each second reader received written instructions that explained the research question, the inclusion and exclusion criteria and how to include articles based on the title. Any disagreement about inclusion of an article based on the title was discussed and resolved through consensus between the first author and the second reader.

Secondly, two authors (EP and SD) assessed the inclusion by abstract. Articles without abstract were excluded. EP and SD discussed doubtful in- or exclusion. The focus was on empirical studies involving doctors of the ethnic majority and patients of the ethnic minority (table 2).

Finally, the full texts of the remaining articles were screened for in- or exclusion by a medical doctor (EP) and an intercultural communication specialist (CA). In case of dis-

agreement between the two researchers, the first author (EP) discussed the papers with the authors FS or SD until consensus was reached. The definitive and complete reading of all the full papers was done by EP.

Table 2. Inclusion criteria.

Inclusion criteria
Doctor-patient communication (one-to-one)
Cultural difference: the doctor of the dominant ethnicity, the patient of the minor ethnicity
Medical setting
English abstract available
Empirical papers, qualitative or quantitative, except: letters, reviews, comments, case reports, books and editorials
No use of interpreter
No use of training the doctors or the patients
No language restriction

Data analysis and synthesis

The review team agreed on what type of data to extract from the included articles, and one reviewer (EP) extracted the data and identified the CMO configurations in each study. The following information was culled: participant characteristics, methods used (i.e. qualitative vs. quantitative), country of research, study design, main results, frame of reference and level of contribution.

We assessed the level of contribution based on relevance and rigor of the articles. This was not to judge the methodological quality of the articles, but to give insight into their degree of importance for answering our specific research question. The rigor was indicated by assessing whether 'the method used to generate that particular piece of data was credible and trustworthy' (high or low). The relevance was indicated by assessing whether 'the article contributed to answering our research question' (high or low). The two assessments were combined in one score for the level of contribution: high (high/high), medium (high/low or low/high) or low (low/low). For example, if the paper included clearly described and trustworthy methods, the level of contribution in terms of rigor was assessed as high. If a paper about ICC described only a small section of ICC between the doctor and the patient and answered the research question only partly, the level of contribution in terms of

relevance was assessed as low.

Data synthesis was undertaken by the first author (EP), and synthesis results were regularly shared and discussed within the research team to ensure validity and consistency. The research team discussed all the extracted data to find overarching categories in the context-mechanism-outcome model. Specifically, we attempted to identify factors which could facilitate or hinder the communication and then sought to explain these and formulate a relevant framework.

Results

Characteristics

For this realist review we considered 51.179 articles, 145 of which met the final inclusion criteria. The included articles were written in English, French, German, Italian and Norwegian. All but 5 articles[31-35] were from Western countries. The 5 remaining articles were from Israel[31] and South Africa.[32-35] The selection process and subsequent categorisation are summarised in figure 1. Appendix B presents the characteristics of the included articles and the level of contribution. After discussion within the research team, we identified the emerging factors influencing ICC and categorised them in terms of contexts, mechanisms and outcomes of ICC. The context factors are the four major communication challenges of ICC: language differences, differences in perception of illness and disease, different perceptions of the social component of health communication, and doctors' and patients' prejudices and assumptions. Following these challenges, we described the mechanisms by objectives, specific skills and core skills. Core skills can be regarded as the main skills of communication doctors should use in their consultation, for example listening. Specific communication skills are the skills a doctor needs in specific situations or contexts, for example in issues with gender, cultural and social diversity or end-of-life care.[4] The outcome is described as a barrier or facilitator for the communication (figure 2). These descriptions included the outcome in the perception of the doctor or the patient, for example feelings of frustration or satisfaction. The overall results are shown in table 3. In the following paragraphs we describe the challenges and their mechanisms with examples.

Figure 1. Flowchart of included articles

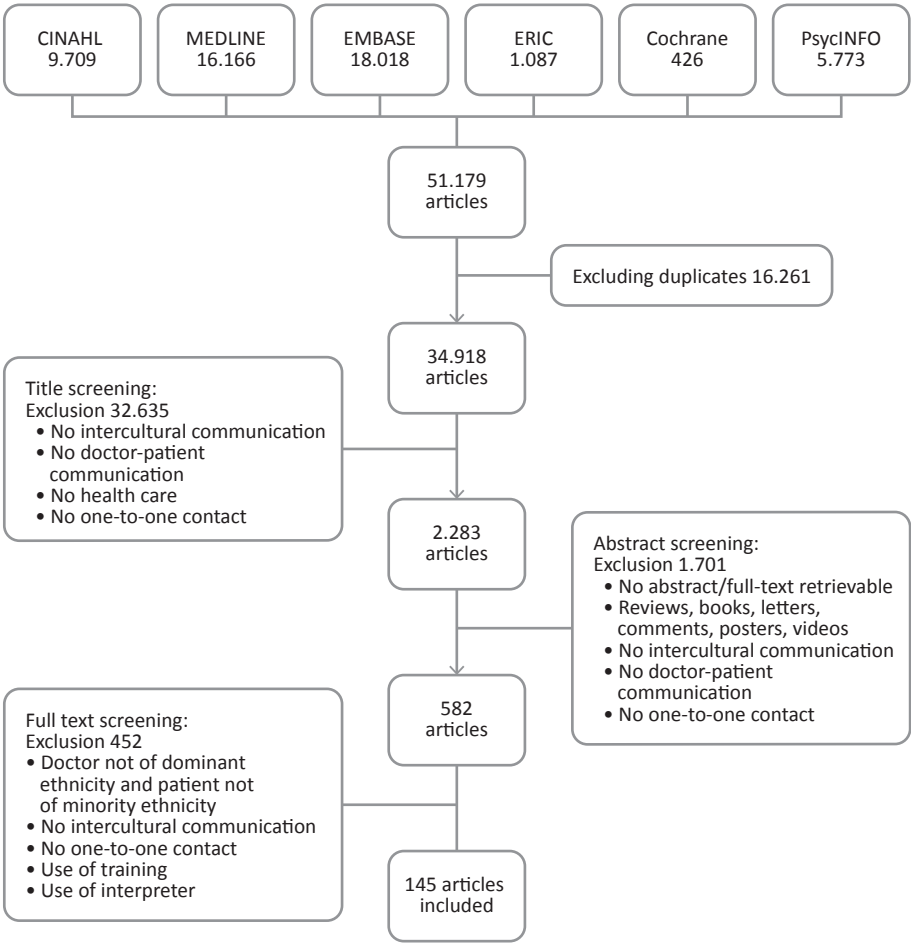

Figure 2. Context-mechanism-outcome framework for intercultural communication.

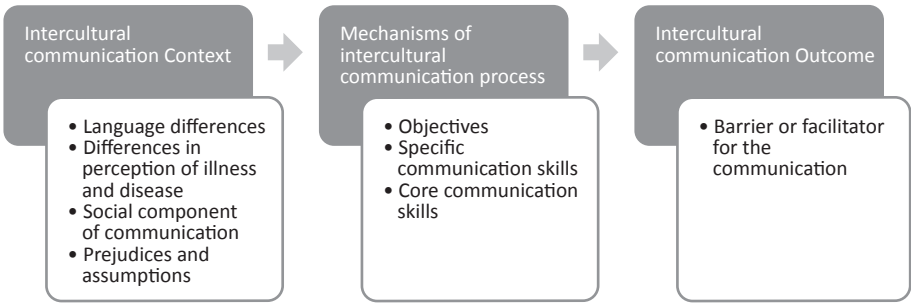

Table 3. Different contexts with the mechanisms of the communication process to facilitate the intercultural communication; summary of the results.

Intercultural communication Contexts ⟶	Mechanisms of the process of intercultural communication ⟶			Communication Outcomes
Communication challenges	Objectives	Specific skills	Core skills	Communication outcome
Language differences	-Knowledge of languages -Understanding the patient	-Being able to speak a few words in the patient's language -Recognising misunderstandings caused by language differences -Using attributes for explanation (pictures, interpreter) -Paying attention to pronunciation -Using various ways of providing explanations	-Giving information in pieces -Checking if the patient understood -Active listening -Sharing decision making -Avoiding unnecessary medical jargon -Adapting the explanation to the patient -Paraphrasing and repeating the patient's exact words	Barrier or facilitator for effective communication about substantive health care issues
Differences in perception of illness and disease	-Knowledge of cultural differences -Awareness of cultural differences (different paradigms) -Expectation management regarding the health care system -Mutual understanding -Respect -Patient-centred communication (shared decision making)	-Recognising misunderstandings caused by cultural differences -Recognising the patient's expectations of the health system -Awareness of one's own culture	-Respecting the patient's habits, norms and values -Becoming familiar with the situation and context of the patient -Understanding the patient (empathic communication) -Informing the patient about the medical procedures/system -Having an open attitude -Explaining -Time management -Active listening -Demonstrating trustworthiness -Handling emotions	
Social component of communication	-Knowledge of position of relatives -Awareness of the role of relatives for the patient	-Knowing the relatives of the patient -Showing interest in the relatives	-Relation building with family and patient -Handling emotions	
Prejudices and assumptions	-Knowledge of cultural differences -Awareness of cultural differences	-Awareness of one's assumptions regarding cultural differences -Dealing with a patient's negative previous experiences	-Learning from previous experiences -Open attitude -Handling emotions -Showing respect -Demonstrating trustworthiness	

Language differences

The influence of language on the communication was mentioned frequently. Language differences literally caused miscommunication.[33,34,36-66] Language differences were seen as important barriers of ICC, because of their relation with misunderstandings, frustration and situations in which it is not possible for the doctor to achieve shared decision-making.

For doctors, the objectives during a consultation were found to focus on understanding the patient and on knowledge of languages. This did not mean that the doctor should be able to speak all the languages of his or her patients; communication was facilitated when a doctor knew a few words of the language of the patient, because this helped to build a relationship with the patient.[67-70]

During an intercultural conversation, the doctor needed specific skills to facilitate the communication. These skills mainly involved various ways of providing explanations and the ability to use extra attributes, such as pictures or an interpreter, in case of language differences.

Besides these specific skills, the included articles mentioned many communication skills that are useful in any doctor-patient conversation. These core skills were for example listening[47,71-83], explaining and avoiding medical jargon. Also, both patients and doctors felt more satisfied when the doctor checked the patient's understanding.[58,72,84-89] For example, paraphrasing and repeating the patient's exact words encouraged the patient to elaborate on his or her concerns.[90]

Together, the communication objectives, the core skills and the specific skills would help to facilitate successful communication between doctors and patients. This is confirmed by the large number of articles which reported that patients found it more important for the doctor to have good language skills than to have the same ethnicity as the patient.[36,52,55,65,66,82,91-96]

Differences in cultural perception of illness and disease

As described in many articles, language is not the only challenge in ICC. Even between patients and doctors who spoke the same language, misunderstandings were common if their ethnic background differed, because these doctors and patients had different cultural paradigms. Consequently, their perceptions of illness and health were influenced by different religions, norms and values.[35,45,48,95,97-105] Patients who had a hierarchical worldview, for instance, were not used to reflecting on their own thoughts about illness, which made it difficult for them to answer some questions

commonly asked by doctors.[38,106] Some patients used religious arguments to explain their condition. For example, they replaced the cause of a disease with another aetiology which was more in line with their religious beliefs.[100]

The objectives that need to be reached to deal with these challenges were identified as knowledge and awareness of cultural differences, management of the patient's expectations of the health care system, mutual understanding[40,48,75,78,81,85,91,107-109], and patient-centred care.

Cultural awareness entails specific skills such as recognising and knowing one's own and other people's cultural identities and beliefs. ICC was influenced both by the doctor's level of self-awareness and by his or her level of awareness of the patient's culture. Two studies reported that ICC was hindered by the lack of cultural awareness of both patient and doctor, which prevented them from understanding each other's deeply entrenched attitudes.[47,52] In four studies, ICC was facilitated when the doctor was aware of his own culture.[31,43,110,111]

For doctors, another main objective in ICC was to manage patients' expectations of the health care system. For example, it was often reported that patients with different ethnic backgrounds did not know how to enter the healthcare system, how to make an appointment with the doctor or which doctor they should visit. In this context, the patients' insufficient organisational and medical knowledge caused them, for example, to visit the wrong doctor, which led to unsatisfactory communication outcomes.[35,40,45,48,67,81,102,104,112-115] It also contributed to feelings of frustration among doctors[48,68,70,116,117], indicating that it would be a valuable specific skill for doctors in ICC to be able to recognise misunderstandings caused by cultural differences and, at the same time, to recognise a patient's expectations of the health care system.

Some articles mentioned that patient-centred communication could be the solution to barriers in ICC.[96,114,118-120] Many doctors learned to practice patient-centred communication in terms of shared decision-making[64,121-125] and activating patients.[34,91,109,126-129] Some studies found that shared decision-making also facilitated communication in ICC, but other articles showed that patients of ethnic minorities, especially the non-Western minorities, viewed the doctor as a person with a high social status and regarded it as disrespectful to contradict the doctor (paternalism).[43,72,79,88,90,97,122-124,127,130-140] In these cases, patient-centred communication might be a effective approach for ICC.

To deal with cultural differences in the perception of illness and disease, doctors were found to need several core skills, such as having an open attitude[141,142], use

of empathic communication[79,93,108,122,128,143-149], showing trust[42,47,78,79,142,150,151] and being respectfull to the patient.[54,73,76,78-80,83,84,87,105,114,152] Also, adequate time management[54,76,79-83,87,89,105,107,108,152], providing explanations[34,73,76,80,85,100,102,107,108,119,149,152] and giving appropriate information[63,69,84,87,110,114,121,127,131,132,147,153-155] were mentioned as core skills for a doctor to facilitate ICC communication.

Social component of communication

Another contextual (influencing) factor was the social component of ICC. Many ethnic minority patients considered it very important that the doctor showed interest in the wellbeing of the family or talked with the family when present[31,40,134,156] and tried to build trust in the relation with the patient.[54] This was an important contextual issue, but often the doctors did not recognise it, as they were used to directing their communication at the individual patient rather than at the family (specific skill).[38,51,157] For patients, their illnesses were connected to their community context and family; relations, culture and values were inseparable.[39,57,64,89,156,158-161] Here, miscommunication (outcome) occurred because doctors and patients had different perceptions of the role of the family. Therefore, knowledge about expectations and habits of the patient and his family[35,81,94,102,114,162-164] were described as specific skills. The core skills to reach the objectives were defined as building a relationship with and handling the emotions of the patients and their families. When the doctor knew the situation and context of the patient, he adapted his behaviour to expectations of the patient, which improved the communication outcome.[39,40,43,57,113]

Prejudices and assumptions

The last identified challenge for communication were prejudices and assumptions of doctors about ethnic minority patients. This contextual factor had similar objectives as the context factor 'differences in cultural perception'; i.e. knowledge and awareness of the cultural differences. For these objectives, the specific skills recognised in the included articles were demonstrating trustworthiness and the doctor's awareness of his or her own assumptions, sometimes caused by previous experiences.[94] Dealing with previous experiences of patients was seen as a core skill of the doctor. These experiences of patients were mostly negative and therefore recognising them was important to facilitate the communication.[32,42,76,151,165,166] For example, some doctors generalised their thoughts about patients of one ethnicity under the same heading.[141] As a reaction to this mechanism, some patients felt discriminated and treated

unequally.[102,118,132,167-169] ICC was influenced both by the doctor's lack of awareness and by the patient's feelings.

Discussion

The aim of this review was to summarise the current knowledge on the factors that influence ICC and to explore the mechanisms through which these factors influence ICC. The use of a realist synthesis provided the opportunity to include a broad range of papers and to explore the context, mechanisms and outcomes in each of the included articles. From a total of 145 included articles, we derived four communication challenges (contextual factors) and several objectives and communication skills (mechanisms) whose absence or presence constituted barriers or facilitators, respectively, for ICC (outcomes). The communication skills could be divided into core communication skills, which doctors should use in any interaction with patients, and specific communication skills for intercultural doctor-patient communication. Reflecting on our research question, we arranged the influencing factors in a framework (figure 2) that clarifies which skills should be trained to enable doctors to deal with each of the challenges of ICC.

One of the new insights of this realist review is that the findings of the ICC literature can be translated into an educational framework in response to 4 contextual challenges. Another new insight is that the framework distinguishes between core communication skills that are largely covered by training programs for patient-centred communication, and ICC-specific communication skills that can be developed as an extension of the existing training programs. Doctors who want to facilitate successful intercultural communication with patients should be aware of the contextual challenges and should acquire and use the core and specific communication skills to reach the communication objectives and overcome the contextual challenges. We do not mean to imply that doctors will need to develop proficiencies in each of the skills equally. For example, doctors who know nothing about the patient's culture (specific skills) might still provide excellent care by employing the appropriate core skills, which may well lead to a positive communication outcome. Also, the cultural content of some encounters may be more challenging than the content of others. Rather than one discrete skill, an integrated set of specific communication skills emerged as the key to successful ICC.

We have provided insights into the core communication skills and the specific communication skills that are important for ICC which can be translated into practical

points for training. Since effective ICC seemed to have many similarities with patient-centred communication, the core communication skills are similar to the patient-centred communication skills as provided in the six function model of medical communication by de Haes and Bensing.[170] This finding is in line with findings of Teal et al. in their article about culturally competent communication.[9] However, while patient-centred communication emphasises improving the quality of individual communication[170], ICC stresses equitable distribution of quality communication among diverse ethnic groups, highlighting a different focus. Since patient-centredness is increasingly regarded as crucial for the delivery of high quality care by doctors[171], the recognition of the similarities between patient-centredness and ICC is important.

Our findings in this review support earlier research in the area of ICC. The review of Schouten et al.[12] showed five key predictors of challenges in ICC, two of which are comparable with our results: cultural differences in explanatory models of health and illness and linguistic barriers. Schouten et al., however, did not provide mechanisms for counteracting these challenges.[12] Furthermore, our results have similarities with the model of culturally competent communication (CCC) of Teal et al.[9], who found four critical elements of CCC, i.e. repertoire, awareness, adaptability and knowledge, and gave a very clear summary of the main CCC skills.[9] In contrast to the study of Teal et al., however, we also found that language was a potential influencing factor of ICC. What our study added to the study of Teal et al. is the systematic search and the fact that we identified specific and core communication skills, which can be translated into communication training.

The anthropological research of Arasaratam et al.[172] described several theories of ICC. One of these theories, the system theory approach[173], distinguishes between cultural competence and ICC competence. This approach explained that being competent in a particular cultural context does not necessarily imply ICC competence and that in an intercultural context the adaptability of a person is displayed in the ability to be flexible in unfamiliar cultural situations.[173] We think that this approach emphasises the importance of our research on ICC and of the development of training in this specific area.

As described earlier, ICC has gained attention during the last years, but it has not yet structurally been implemented into all medical curricula of multi-ethnic societies. This situation does not comply with our multi-ethnic societies' demand for doctors with cultural diversity competencies.[13-15] Strategies to encourage reflective practice in the context of ICC skills training may be more successful than overt attempts to

change attitudes.[174] A skill-based approach may therefore be less threatening than a theory-based approach and can be reinforced by assessment of competencies and behaviour.

The realist perspective of this review provided the opportunity to examine a wide range of papers in the complex field of ICC and to look at this complex area. This helped to gain insight into the process of ICC. The results did not focus on healthcare outcomes, but on factors which influenced the communication process, in order to identify barriers and facilitators of effective communication in the context of ethnic differences between the doctor and the patient. A strength of this study was the broad research question and search, which enabled us to include many papers about ICC in healthcare. Also, the results were strengthened by the inclusion of studies on both the doctors' and the patients' perspectives, because both parties influence the communication and therefore both voices need to be heard. However, as the search was so broad, it was not possible to include the references of the included articles as well, although we expect that most of them were already included as primary results of our broad search. Another limitation was that the healthcare workers we focussed on in this review were doctors; while there are many more healthcare workers who need to deal with the difficulties of ICC in practice, our special focus is due to our interest in developing training programs for doctors. This particular interest also explains why we limited our search to studies that did not include the use of interpreters, since this could influence the interaction and can give bias for answering our research question.

As in all systematic reviews, selection and publication bias is a possible limitation of the present study. However, we aimed to prevent this by extending our search beyond articles written in English and by placing no restrictions on the year of publication. Another limitation could be that we did not test our theory by means of secondary searches. Also, we were not able to distinguish between the different ethnicities within the included articles. As a consequence, we did not describe the interethnic differences. Nor did we investigate the effects of non-verbal communication per se, which also influences the outcome of intercultural doctor-patient communication.

This research identified a number of influencing factors that shape the ICC process between doctors and patients. Future research might focus on how these factors could be used and managed at a practical level. Firstly, this would involve checking our findings by examining real-life consultations. Secondly, the mechanisms we identified could be used for the development of communication training and assessment

for doctors. As Kai et al. already stated in 2001, uncertainty about the assessment of cultural diversity still needs attention.[16]

Conclusion

We identified communication challenges, objectives and skills that result in barriers or facilitators for intercultural doctor-patient communication. To overcome the challenges, training for doctors should focus on the core communication skills and the specific communication skills that can produce positive outcomes for ICC. The core communication skills required for ICC were similar to the skills for patient-centred communication, but ICC was more susceptible to imbalances in the communication process when cultural differences in the perception of illness and disease were ignored. The insights into the specific skills required to meet ICC challenges in health care provide important information for the development of communication training for doctors.

Implications for practice

Training programs for improving intercultural doctor-patient communication can be developed as an extension of the existing training programs for patient-centred communication. The description of objectives and specific and core communication skills can be used to translate of ICC theory into clinical practice.

The main educational objectives per contextual challenge are as follows:

- Language differences: knowledge of languages and recognising misunderstanding
- Difference in perception of illness and disease: patient-centred communication, awareness of cultural differences, doctors' awareness of their own culture and expectation management
- Social component of communication: knowledge about the role of the patient's family
- Prejudices and assumptions: awareness of one's own assumptions

Appendix A. Example of search string.

Search string MEDLINE	
#1	language*[tiab] OR communicati*[tiab] OR Communication[Mesh] OR "Professional-Patient Relations"[Mesh] OR contacting client*[tiab] OR medical consult*[tiab]
#2	"Internship and Residency"[Mesh] OR physician*[tiab] OR nurse*[tiab] OR doctor*[tiab] OR professional*[tiab] OR gp[tiab] OR gps[tiab] OR practitioner*[tiab] OR provider*[tiab] OR resident*[tiab] OR intern[tiab] OR interns*[tiab] OR postgraduate*[tiab] OR post graduate*[tiab] OR house officer*[tiab] OR house staff[tiab] OR registrar*[tiab] OR specialist training*[tiab] OR trainee*[tiab] OR clinician*[tiab] OR attending*[tiab] OR consultant*[tiab] OR medical specialist*[tiab]
#3	patient[tiab] OR patients[tiab] OR client*[tiab] OR health consumer*[tiab]
#4	relation*[tiab] OR interaction*[tiab] OR interview*[tiab] OR communicati*[tiab]
#5	((#2) AND #3) AND #4
#6	(#1) OR #5
#7	"Delivery of Health Care"[Mesh] OR "Physicians, Primary Care"[Mesh] OR "Primary Care Nursing"[Mesh] OR "Primary Health Care"[Mesh] OR "Hospitals"[Mesh] OR healthcare[tiab] OR health care[tiab] OR primary care[tiab] OR hospital[tiab] OR hospitals[tiab] OR general practice*[tiab] OR family practice*[tiab] OR secondary care[tiab] OR medical practice*[tiab] OR medicin*[tiab]
#8	Cultur*[tiab] OR Crosscultural* OR Cross cultural* OR Intercultural*[tiab] OR Multicultural*[tiab] OR Transcultural*[tiab] OR Interracial*[tiab] OR Ethnic*[tiab] OR Diversit*[tiab] OR Migrant*[tiab] OR Immigrant*[tiab] OR Minorit*[tiab] OR Race[tiab] OR Racial*[tiab] OR Emigrants and Immigrants[Mesh] OR Emigration and Immigration[Mesh] OR Cultural Diversity[Mesh] OR Ethnic Groups[Mesh] OR Minority Groups[Mesh]
#9	((#6) AND #7) AND #8
#10	"Review" [Publication Type] OR "Ephemera" [Publication Type] OR "Comment" [Publication Type] OR "Case Reports" [Publication Type] OR "Editorial" [Publication Type]
#11	(#9) NOT #10
#12	#11 AND has abstract

Appendix B. Table with article characteristics of the included articles, described by context (participants, ethnicity, setting), mechanism and outcome (results).

Author, year	Language	Design, method	Participants	Theory	Ethnicity patient	Setting, country	Results	Frame of reference	Level of contribution (1,2)*
Sheets et al. 2012	English	Qualitative, interview	14 mothers	None	Spanish speaking Latina's	Down syndrome, US	The mothers desired the news in a more positive, balanced light and with more complete explanations (less medical jargon, less scientific description, slower pace). Participants used religious beliefs to explain the reason for the condition.	Patient	High (+/+)
August et al. 2011	English	Mixed, interview	2.960 adults	None	Latino, vs Asian Pacific	Mental health, US	There were no significant differences between language-discordance and English language-concordant older adults in predicting discussion on mental health concerns.	Patient	Medium (-/+)
Watt et al. 2011	English	Qualitative, grounded theory, interview	50 parents	None	Chinese and South Asian	Oncology, Canada	Parents were highly satisfied with the care, but not comfortable with providers communicating sensitive health issues directly to the child. A part of communication is understanding of the dr.	Patient	Low (-/-)
Ameresekere et al. 2011	English	Qualitative, interview	23 patients	None	Somali women	US	Experiences and cultural beliefs of pts influenced thoughts of pts about healthcare. Misperception causes fear. Pts want a clear explanation of the procedure. Pts had little personal knowledge and limited discussion with drs.	Patient	Medium (-/+)
Villagran et al. 2012	English	Quantitative, structural equation modeling (survey)	217 patients	Burgoon 1996 + Harwoow and Giles 2005	Mexican	US	Culture plays a fundamental role in healthcare interactions. Mexican immigrant pts desired linguistic accommodation from drs. Cultural identity played an important role in expectations of the medical visit. Complex relation between out-group perception (immigrant status) and adherence.	Patient	High (+/+)
Song et al. 2011	English	Qualitative, interview, grounded theory	28 patients	None	African American	Oncology, US	4 domains: pts want open communication of cancer info, experience lack of shared decision making, empathy and understanding, respect. Not knowing what questions to ask and not understanding contributed to limited discussion. Facilitator: dr who attentively listened, provide encouragement, demonstrating non-verbal behaviours of caring. Barriers: dr uses inappropriate language, no time, pt experience discrimination.	Patient	High (+/+)
Simonds et al. 2011	English	Quantitative, interview, critical incidence	35 patients, 16 providers (presumably dr)	Roter and Hall 1987, Betancourt 2003	American Native (minor)- non-Native	Gynaecology, US	Trust is central in dr-pt communication, influenced by context, expectations, history and time. Barrier: expecting pts to discuss important things right away (dr), lack of continuity of care (dr+pt), waiting time (dr+pt), visit context (reason and situation), stories (pt). Facilitator: visit context (reason and situation), extra time (dr), receiving advice and educational information (pt), concern of dr (pt).	Patient + doctor	High (+/+)
Maesschalck et al. 2012	English	Quantitative, Interview + video	191 videos, 77 doctors	None	Mixed	Primary care, Belgium	Language problems or pure biomedical consultations resulted into less emotional cues. Pts' language proficiency had a more important impact on the number of cues expressed by the pt than cultural difference. Barriers: language and acculturation.	Observer	High (+/+)

Gurnah et al. 2011	English	Qualitative, interview, focus group, questionnaire	39 women	None	Somali Bantu	Reproductive health, US	Barriers to healthcare and good communication are miscommunication (language), mistranslation and lack of self-advocacy, lack of cultural fluency (understanding the deeply entrenched attitudes, behaviour).	Patient	Medium (-/+)
Kale et al. 2011	English	Quantitative, observation	56 consultations/patients, 26 doctors	None	Immigrants vs Norwegian patients	Norway	Immigrant pts without language problems expressed more worries than with language problems and Norwegian pts. No differences in emotional cues between immigrant pt and Norwegian. Barriers: language proficiency of pt.	Observer	High (+/+)
Quinn et al. 2011	English	Qualitative, questionnaire	91 patients, 72 oncologists	None	Spanish speaking	Oncology, US	Pts felt knowing less and it is important to be able to communicate in their preferred language with their dr. Drs want to be more informed about communication difficulties.	Patient + doctor	Low (-/-)
Hausmann et al. 2011	English	Quantitative, audiotapes	353 patients, 63 orthopaedic surgeons	None	African American vs White	Orthopaedics, US	Perceptions of past racism in healthcare may negatively impact the affective tone of pt-dr communication. Barriers: experience of discriminationà has ess positive nonverbal affect, less dr warmth, less ease of communication.	Patient + observer	Medium (-/+)
Degni et al. 2012	English	Qualitative, focus groups, interviews	10 doctors	None	Somalia patients	Gynecology, Finland	Cultural differences cause communication problems. Cultural traditions and beliefs were unfamiliar to drs. Drs are not able to communicate directly to several Somali women. Drs have no time to socialise. Barrier: inactive role of the dr.	Doctor	Medium (-/+)
Horn et al. 2011	English	Qualitative, survey	425 parents	None	African American	Paediatrics, US	Most pts perceived that the dr used moderate/high partnership-building communication. Concordance of dr-pt does not play a significant role in pt perception of partnership in the relation with the dr.	Patient	Low (-/-)
Bullock 2011	English	Qualitative, interview + focus group	202 adults	Johnson, Kuchibhatla and Tulsky 2008	Black vs White	End-of-life care, US	Black pts expressed feelings of mistrust and lack of positive relationship with a 'regular' dr. Black pt wants the family to be part of the decision. Black pts have more negative experiences. Black pts talk more about their belief in miracles.	Patient	Medium (-/+)
Butow et al. 2011	English	Quantitative, audiotapes + questionnaire	141 audiotapes, 10 oncologists, 15 immigrants	None	Immigrants vs Anglo-Australian	Oncology, Australia	Drs spoke less to immigrants, spent less time to cancer related issues, summarising and informing, but more time to other medical issues and advising. Drs tented to delay responses to or ignore more immigrant than Anglo-Australian cues.	Observer	Medium (-/+)
Gulati et al. 2012	English	Qualitative, interviews, grounded theory	50 patients	None	South Asian	Paediatric oncology, Canada	Communication challenges influenced parents' role in caring for their child and made it difficult to learn complex medical terminology. The ability to communicate effectively (non) verbally played an important role in immigrants health care experiences. Social aspects are important in communication.	Patient	High (+/+)
Mitchison et al. 2012	English	Qualitative, interview	73 patients	None	Mixed	Oncology, Australia	Pts preferred prognostic info to be delivered in a caring and personalised manner from an authoritative dr. Some family members wanted to speak to the dr first to direct the info to the pt. Most pts want open communication about their prognosis in a positive way.	Patient	High (+/+)

Wilkins et al. 2011	English	Quantitative, survey	111.139 parents	None	Mixed	Paediatrics, US	Experiences with dr communication were the strongest predictor rating a dr and healthcare poorly. Bad communication caused negative experiences. Facilitator: dr with respect, time, listening and explaining skills.	Patient	Medium (-/+)
Scholl et al. 2011	English	Qualitative, questionnaire	50 patients, 8 doctors	Communication Theory of Identity 1988 (Collier&Thomas)	Mixed	US	There is interplay between culture communication and language. For some pts ethnicity of the dr didn't matter. Pts and drs communicate their ethnic identity in similar (language is the primary source of difficulty) and different ways. Barriers are: accent, rate of speech, perceived rudeness, frustration, lack of understanding by other party.	Doctor + patient	High (+/+)
Suurmond et al. 2011	English	Qualitative, interview	22 patients	None	Mixed	The Netherlands	Pts experience negative events, exchange of information, different expectations, feeling mistreated (discrimination). Illness perspective of pts and disease perspective of drs are different.	Patient	High (+/+)
Hausmann et al. 2011	English	Quantitative, audiotapes, survey, medical record analyses	402 patients	None	African American vs white	Orthopaedic, US	Visit with AA pt contained less discussion of biomedical topics and more rapport building statements. No differences in length, discussion psychosocial issues, pt activation, dr verbal dominance.	Observer	High (+/+)
Singh-Carlson et al. 2010	English	Qualitative, interview	11 women	None	South-Asian	Oncology, Canada	Influences of experiences of respect are language, cultural values and beliefs, societal, individual and institutional factors. Pts want to be seen as an individual. Greeting is important. Ill pts preferred to talk in their own language. The way drs talk opens or closes the door. Most pts were positive about the communication style of drs.	Patient	Medium (-/+)
Weinick et al. 2011	English	Quantitative, written + video vignette, questionnaire	567 patients	None	White, African American, Latino	Disparity care, US	Different ethnic groups have generally similar expectations regarding drs' behaviours, with the exception of extent to which they treat all pts fairly regardless of race. Behaviour of drs is interpreted in different ways. Pts thought that some to all drs have positive behaviours towards them. AA, Latino pts think that they are treated unfairly in comparison with white pts.	Patient	Medium (-/+)
González et al. 2010	English	Quantitative, interview	2921 patients	None	Latino	US	In pt-dr discordance Latino pts rated their health care lower. Language concordance à less confusion and frustration.	Patient	Low (-/-)
Sheppard et al. 2011	English	Qualitative, interview	49 women	None	Black	Oncology, US	The pt-dr relationship was the most notable factor that influenced treatment decisions. Most pts were satisfied with the relationship, but their narratives were not. Communication with the dr was described as good. Not all pts want to be completely informed. (collectivism)	Patient	High (+/+)
Mack et al. 2010	English	Quantitative, interview, medical report analyses	323 patients	Viswanath et al. 2007	Black vs White	Oncology, US	Black pts have less end-of-life discussions and tend to receive more often life-prolonging measures, probably because of different communication or healthcare access.	Patient	Medium (-/+)

Moreno et al. 2010	English	Quantitative, interview	1.590 patients	None	Spanish speaking Latino's	US	Needing an interpreter and not having one was associated with experiences of lower satisfaction and quality of dr-pt communication (listening, explaining, respect, time).	Patient	Low (-/-)
Sims 2010	English	Mixed, interview	50 women	None	Black	US	Disparities in care are influenced by non-clinical points (i.e. culture). Unfamiliarity with ethnical different thoughts caused miscommunication and misinterpretation.	Patient	Low (-/-)
Manfredi et al. 2010	English	Quantitative, survey (interview)	492 patients	Precede-Proceed Model (Greene&Kreuter 1999)	African American vs white	Oncology, US	AA pts reported more interpersonal communication barriers and have more unmet information needs. AA pts reported poorer dr-pt communication. AA pts asked the same amount of questions as White pts do.	Patient	Medium (+/-)
Peek et al. 2010	English	Qualitative, interview + focus group	51 patients	Shared decision model (Charles, Gafni&Whelan 1997)	African American	Diabetes, US	Influenced shared DM by pt-related factors (all negative): knowledge, attitudes, beliefs, behaviour. Dr related factors: cultural discordance (discrimination). Pts believed that their self-efficacy and communication style accounted for success.	Patient	High (+/+)
Jean-Pierre et al. 2010	English	Quantitative, questionnaire	973 patients	None	White vs non-White	Oncology, US	Differences between white vs non-White pts in concerns of understanding diagnosis and treatment plan. Non-White pts wanted to have more info.	Patient	Low (-/-)
Davies et al. 2010	English	Qualitative, interview (grounded theory)	36 parents	none	Mexican vs Chinese vs American	Paediatrics, US	Pts who received basic information, explanations and attention to questions and emotions reported feeling more informed and less anxious and distressed. There was a language and a cultural barrier.	Parent	Medium (-/+)
Carrion 2010	English	Qualitative, interview	10 doctors	None	Hispanic	End-of-life care, US	Barriers are: language, uncertainty regarding role of family and limited knowledge of cultural factors and beliefs impacted communication related to end-of-life decisions. There are multiple solutions to overcome these barriers (for example: training for dr, more bilingual health staff).	doctor	High (+/+)
Ruppen et al. 2010	English	Quantitative, document analyses (medical records)	285 patients	None	Mixed	Pain treatment, Switzerland	The number of consultations was similar between the groups. The consultation length was shorter with immigrant pts.	Observer	Low (-/-)
Butow et al. 2010	English	Qualitative, focus group, interview	73 patients	None	Mixed	Oncology, Australia	Immigrant pts felt cultural isolated, some felt judged, but expertise of the dr was respected. Some pts suspected that they received inferior care. Pts were concerned that drs gave less information, because the drs did not take the time to overcome the communication barrier or used misplaced paternalism. Some pts found it too hard or demanding to request clarification and they acted as if they understood more than they did.	Patient	High (+/+)
Wallace et al. 2009	English	Quantitative, interview	5197 patients	None	Hispanic	Health services, US	There are very few differences in perceptions of dr communication across subgroups. Some reported that the dr always showed respect for what they had to say. Others indicated that the dr always spent enough time.	Patient	High (+/+)

Jensen et al. 2010	English	Quantitative, survey + interview	131 patients	None	White vs Non-White	US	White pts were more likely than non-White pts to feel that dr did not listen carefully.	Patient	Low (-/-)
Alegría et al. 2009	English	Quantitative, survey	884 patients	None	Latino	US	Us born Latino pts had greater pt activation scores than foreign born Latino pts. Pt activation was associated with self-reported quality of care and better dr-pt communication.	Patient	Medium (+/-)
Garcia et al. 2009	English	Qualitative, interview	4 patients	None	Latino immigrants	Adolescents, US	Immigrant pts experienced access disparities because of language barriers. Language barriers contributed to feelings of dissatisfaction.	Patient	Medium (-/+)
Wiking et al. 2009	English	Qualitative, questionnaire	52 patients, 65 GP	None	Mixed	Health center, Sweden	Some pts experienced language difficulties (because of time, relation problems, explaining of the dr, expressing of the pt). Most pts experienced respect for their culture, personality, and their wishes. Most pts were satisfied with the consultation. Facilitator dr: understanding viewpoint of pt, willingness to listen, and experience of personal connection.	Patient + doctor	Medium (-/+)
O'Brien et al. 2011	English	Quantitative, survey	1267 patients	None	Hispanics	US	Bilingual pts experienced higher satisfaction with dr-pt communication, than monolingual pt. Language preference was not significant associated with pt satisfaction.	Patient	Medium (+/-)
Cené et al. 2009	English	Quantitative, interview + audiotapes	226 patients, 39 doctors	None	Mixed	Hypertension, US	Pt race is associated with the quality of pt-dr communication to a greater extent than blood pressure control. Black pt with uncontrolled blood pressure had the shortest visits. Uncontrolled Black pts had a less emotional positive tone and experienced worse communication.	Observer	Medium (+/-)
Shadid et al. 2009	English	Qualitative, interview	30 patients	None	Aboriginals	Oncology, Australia	Barriers for effective communication for pts are: history and racism, lack of understanding about culture and life circumstances, an alienating hospital environment which caused language barriers, inadequate information and explanation, differences in comm style, non verbal cues, body language, lack of respect for privacy. Facilitators for pts are: cultural sensitive dr, empathic personal contact, acknowledgment and respect for pt culture.	Patient	High (+/+)
Sudore et al. 2009	English	Quantitative, questionnaire	771 patients	None	Spanish speaking	US	Language barriers gave less interactive communication style. Limited health literacy impedes dr-pt communication, but its effect varies with language discordance and communication type (receptine, proactive, interactive).	Patient	Medium (+/-)
Ge et al. 2009	English	Qualitative, videotapes + interview	44 videos	Hofstede 2001	Mixed	Oncology, US	During consultation there was little attention for culture. Facilitators for pts are: trust, power distance, health beliefs, directness, dependency, authoritative voice knowledge, ability to listen, and expertise of the dr.	Observer + doctor + patient	High (+/+)
Berkman et al. 2009	English	Quantitative, interview	26 patients	None	Korean American	Oncology, US	Most pts wanted their dr to tell them the diagnosis. Some pts preferred disclosure about serious illness. Pts wanted to understand the dr and wanted the dr to determine what, how and when for each pt.	Patient	Medium (-/+)

Wiking et al. 2009	English	Quantitative, questionnaire	52 patients	None	Mixed	GP, Sweden	Most pts experienced respect for their personality, wishes and culture, and were satisfied. Barriers for pts were: language and cultural differences, drs that are unable to listen or to understand.	Patient	High (+/+)
Eamranond et al. 2009	English	Quantitative, document analyses	306 patients, 55 doctors	None	Spanish speaking	Primary care, US	Language discordance dr-pt communication documented less about diet and physical activity.	Observer	Low (-/-)
Williams et al. 2008	English	Qualitative, focus groups	42 patients	None	African American	Oncology, US	Effective communication and decision making are fundamental to overall quality of life. Drs were viewed as having the responsibility to establish and monitor effective communication. Drs needed to know the pts and family and tailor communication on this knowledge (appropriate language and amount and timing of information).	Patient	High (+/+)
Julliard et al. 2008	English	Qualitative, interview (grounded theory)	28 women	None	Latina	US	Dr-pt relationship is very important. Pts will not share information if the dr is has no compassion, trust, caring, human interest and respect. Pts experienced difficulty disclosing information because of language barrier. Barriers were time constraints and cultural differences. Pts expressed that being listened and heard by drs were important.	Patient	High (+/+)
Korthuis et al. 2008	English	Quantitative, interviews	717 patients	None	Mixed	US	The relationship between pt-centred communication and race is complex. Most pt rated dr communication favourably. Black pt reported more positive experiences than White pt. Pts reported that drs explain things, listen and respect.	Patient	Medium (-/+)
Wallace et al. 2009	English	Quantitative, telephone interview	5197 patients	None	English speaking or Spanish speaking	US	English pts reported positively about communication with the dr. Most English responders reported that the dr listened, explained, showed respect, spent enough time and ask to help the pt in making the decision.	Patient	High (+/+)
Hawley et al. 2008	English	Quantitative, questionnaire	877 women	None	Mixed	Oncology, US	Despite similar outcomes, pts reported very different experiences with treatment decision making. Latina pts have the highest decision dissatisfaction. Ethnic minority pts more often preferred interpersonal sources of information.	Patient	Low (-/-)
Harmsen et al. 2008	English	Quantitative, interview	663 patients, 38 doctors	None	Western vs non-Western	GP, The Netherlands	Cultural views and language proficiency are more important for the evaluation of care than ethnic origin. Non-Western pts perceived less quality of care and were less satisfied than Dutch-born pts. With a bad Dutch language proficiency, pts were more negative about the communication process.	Patient	High (+/+)
Street et al. 2008	English	Quantitative, cross sectional	214 patients, 29 doctors	None	Mixed	Outpatient clinic, US	Race concordance is primarily predictor of perceived ethnic similarity, but several factors affect perceived personal similarity, including drs' use of pt-centred communication.	Patient	Low (-/-)
Babitsch et al. 2008	English	Quantitative, questionnaire, documents	2429 doctors	None	Turkish vs German	Emergency department, Germany	Good communication is crucial for a satisfactory dr –pt relation, dr satisfaction is significant lower with ethnic different pts. Language barriers have negative impact on dr-pt relationship and satisfaction with of the dr.	Doctor	Medium (-/+)

Levinson et al. 2008	English	Quantitative, audiotapes + questionnaire	886 patients, 89 doctors	None	African American vs White	Surgery, US	White pts rated the communication and satisfaction higher than Black pts. The content of informed DM conversations does not differ by race.	Patient + observer	Medium (+/-)
Schouten et al. 2009	English	Qualitative, videotapes + survey	103 patients , 29 doctors	Roberts et al. 2002	Mixed	GP, The Netherlands	GPs interacted less stimulatingly with minority pts. Consults with ethnic minority pts were with less stimulating utterances, less 'joint problem solving' and less schedule-driven. Drs involved ethnic minor pts less in the DM process and checked less often whether they understood.	Observer	High (+/+)
Kushnir et al. 2008	English	Quantitative, questionnaire	193 patients	None	Jewish, Bedouin	Paediatric, Israel	Interpersonal competence and skills of drs were important. General trust in the dr was predicted by interest and collaboration communication styles, but ethnicity was not a significant predictor. The only cultural difference was that Jewish pts reported significantly higher scores than Bedouin pts on collaboration (having common language and similar values)	Parents	High (+/+)
Ghods et al. 2008	English	Quantitative, audiotapes + questionnaire	108 patients, 54 doctors	None	African American vs White	Depression care, US	There were no differences is biomedical or psychosocial statements. AA pts reported less rapport building exchange. No difference in duration of the visit. Dr and pt positive affect were lower in visits of minority pts. AA pts provided cues about their emotional status.	Observer + doctor	High (+/+)
Ngo-Metzger et al. 2007	English	Quantitative, survey	2.746 patients	None	Asian American	Community health center, US	Language barriers were associated with less health education, worse interpersonal care and lower pt satisfaction.	Patient	High (+/+)
Nguyen et al. 2008	English	Qualitative, interview (grounded theory)	20 patients	None	Vietnamese	Oncology, US	Pts were unsatisfied with the dr-pt communication, because discussions were not always taking place; drs didn't talk about cancer and language difficulties. Pts accepted a paternalistic dr-pt relationship.	Patient	High (+/+)
Wearn et al. 2007	English	Qualitative, mixed, interview	80 doctors	None	Mixed	GP, New Zealand	Non-English consultations were associated with higher misunderstanding and interpretation difficulties, because of language difficulties. Information sharing was impeded with language difficulties, which gave worries about compliance, diagnosis and understanding of the pt. The effect of different cultural norms was seen as additional to issues produced by language alone.	Doctor	High (+/+)
Wallace et al. 2007	English	Quantitative, telephone interview	19,6 million households	None	Hispanic White vs non-Hispanic White	Civilian research, US	Hispanic pts reported that their dr listened, explained, showed respect, spent enough time, but reported that the dr gave them control over treatment options.	Patient	High (+/+)
Smith et al. 2007	English	Quantitative, survey	803 patients	None	African-American vs White	End-of-life care, US	Quality of dr-pt relation (respect, listening, DM) was worse for AA pts, except trust.	Patient	Medium (+/-)
Probst et al. 2007	English	Quantitative, survey	1.766 patients	None	Mixed	Depression, US	White pts and Hispanic pts were more likely to communicate about symptoms of depression with the dr than AA.	Patient	Low (-/-)

Schouten et al. 2007	English	Quantitative, videotapes + questionnaire + interview	103 patients, 29 doctors	Street et al. 2002	Mixed	GP, the Netherlands	Non Western ethnic minority pts displayed less participatory behaviour during consultations and less self-diagnose than Dutch pts. Dutch pts asked more (in) direct questions. Drs instrumental and affective behaviour was lower in ethnic minority pts.	Observer + patient + doctor	High (+/+)
Meeuwesen et al. 2007	English	Quantitative, videotapes	103 patients	None	Mixed	GP, the Netherlands	Drs set the agenda. The majority of the consults was traditional or cooperative, especially with minority pts. A conflicting pattern will lead to poor mutual understanding.	Observer	High (+/+)
Kokanovic et al. 2007	English	Qualitative, interview	30 patients	None	Mixed	Diabetes, Australia	Dr used normalizing or catastrophizing strategies. Some pts reported that they received only general information (normalizing), while others reported that the information was difficult to comprehend (catastrophizing). The relationship was hierarchical.	Patient	High (+/+)
Rosenberg et al. 2007	English	Qualitative, interview	23 doctors	None	Mixed	GP, Canada	Most drs focussed on the individual pt. Pt-centred model of care worked effectively in different cultures, but drs had no framework to elicit information about pt' culture. Main strategies of dr were: pt adaption, dr adaption and negotiation.	Doctor	Medium (-/+)
Schlemmer et al. 2006	English	Qualitative, focus groups and interview	5 patients, 6 doctors	None	Xhosa speaking	South Africa	Drs had negative attitudes towards Xhosa speaking pts, because of their previous experiences. Dr experienced that pts didn't understand the diagnosis and medication use. Pts reported that respect implies not querying anything the dr says. Language barriers negatively influenced the attitudes of drs and pts.	Doctor + patient	High (+/+)
Levin et al. 2006	English	Qualitative, questionnaire	53 patients	None	Xhosa speaking	Paediatrics, South Africa	Language and cultural barriers were cited as barriers. Pts experienced difficulties in understanding the dr (terminology), making themselves understood and asking questions. Pts blame their own linguistic limitation.	Parents	High (+/+)
Mutchler et al. 2007	English	Qualitative, focus groups	36 patients	None	Latino	US	Language was a barrier in dealing with medication. Language issues were being linked to perceptions of discrimination. Pts were actively involved in their health care communication obstacles, understanding and participation in DM. Trust is related to language and a key component for pt DM.	Patient	High (+/+)
Ali et al. 2006	English	Qualitative, interview	25 patients	None	South Asian vs White	GP, Great Britain	Pts wanted a dr-centred approach. South-Asian pts had less social conversation. Drs were good listeners. Time management was important for drs to have. 'Foreign ambience syndrome', where pts were seen to complain about trivial matters in which communication between drs and pts is adversely effected by the linguistic incompetence of pt.	Patient	High (+/+)
Meeuwesen et al. 2006	English	Quantitative, video observation	144 videos/ patients, 31 doctors	None	Mixed	GP, the Netherlands	Consultation with minority pts was shorter, greater power distance, drs ask for clarification, gave advice and paraphrased more. Pts of ethnic majority talked more and disagreed more often with the dr. Dr instrumental communication was similar, but less affective communication in minority group.	Observer	High (+/+)

Gordon et al. 2006	English	Mixed, audiotapes analyses	137 patients	None	Mixed	Oncology, US	Minority pts received less information from dr and were less active in the consultation.	Observer	High (+/+)
Towle et al. 2006	English	Qualitative, interview + focus group	22 patients, 2 doctors	Kelly&Brown 2002	Aboriginals	Canada	Barriers in communication were time and history. A facilitator was trust. Pts wanted to be treated as individuals and want time to be heard. Drs needed to understand the history of the pt to build a personal relationship. With negative experiences, pts saw healthcare negative.	Patient + doctor	High (+/+)
Siminoff et al. 2006	English	Quantitative, audiotapes	405 patients, 58 doctors	None	White vs non-white	Oncology, US	Both pts and drs spent time to establish an interpersonal relationship. White pts had more utterances, asked more questions, more involvement in the DM process and gave more biomedical information.	Observer	High (+/+)
Abbe et al. 2006	English	Mixed, questionnaire	17 patients	None	Spanish speaking	Oncology, US	Pts felt scared and worried that they wouldn't understand what the dr had to say. Pt preferred simple language.	Patient	Low (-/-)
Gonzalex-Espada et al. 2006	English	Qualitative, interview	13 patients, 17 doctors	None	Hispanic	Paediatrics, US	Pts felt frustration, uncomfortable and helplessness with a language barrier to understand the dr. Drs reported importance of awareness of cultures and limited ability to understand and speak the same language, which brought concerns about the diagnosis.	Patient + doctor	High (+/+)
Gordon et al. 2006	English	Quantitative, questionnaire	103 patients	None	Black vs White	Oncology, US	Pts reported that drs communicated less supportive, less partnering, less informative with Black pts, which gave lower trust.	Patient	Medium (-/+)
Goldstein et al. 2005	English	Quantitative, interview + questionnaire	214 patients, 92 doctors	None	Mixed	End-of-life care, US	Discussions about prognosis occurred more often in non-white pts.	Patient + doctor	Low (-/-)
Shrank et al. 2005	English	Qualitative, focus groups	70 patients	None	African American vs White	End-of-life care, US	White pts desired more information about medical options; AA pts requested spiritually focussed information. White pts expressed more concern with quality of life while AA pts tended to protection of life at all costs (quantity more important than quality). Pts wanted an autonomous decision with the family.	Patient	High (+/+)
Rosenberg et al. 2006	English	Qualitative, video vignette	24 videos/ patients, 12 doctors	Identity and Co-cultural Theory	Mixed	Family medicine, Canada	Pts often made errors in word use and were conscious of difference accents that may make it more difficult to be understood. Pts failed to understand the dr, but didn't ask for clarification. Drs reported that pts have limited ability to describe symptoms; pts used expressions that were difficult for the dr to decode. Language was a barrier. The interaction was seen as interpersonal rather than intercultural. Dr didn't know the effect of culture on communication.	Patient + Doctor	High (+/+)
Moss et al. 2005	English	Qualitative, video observation	232 videos/ patients, 19 doctors	None	Mixed	GP, UK	Misunderstanding arises owing to a range of linguistic and cultural factors. Including stress and intonation patterns, vocabulary, narrative of pts and the different agendas of drs and pts. The indirectness of the pt is a face saving strategy.	Observer	High (+/+)

Roberts et al. 2005	English	Qualitative, video observation	232 videos	None	Mixed	GP, UK	Misunderstanding because of: pronunciation, word stress, intonation, speech delivery, grammar, vocabulary, lack of contextual information, style of presentation. Communication style is a more important factor than culturally specific health beliefs.	Observer	High (+/+)
Cheng et al. 2004	English	Quantitative, questionnaire	1040 patients	None	Aboriginal vs non-Aboriginal	Anesthesiology, Australia	Communication difficulty in minority pts was pervasive and often unrecognized. Language was a barrier. Minority pts understood less.	Patient	High (+/+)
Sleath et al. 2004	English	Quantitative, interview	141 patients, 80 doctors	None	Hispanic vs non-Hispanic	Depression care, US	Hispanic ethnicity of pts and language were not significant related to dr-pt communication about how to overcome depression.	Patient	Medium (-/+)
Katz et al. 2004	English	Mixed, focus group + survey	45 patients for focus groups,397 patients for survey	None	African American	Oncology, US	Pt-dr communication was a discussion theme. 75% of pts were considered having good communication. Those were more likely to be screened for cancer.	Patient	Medium (+/-)
Johnson et al. 2004	English	Quantitative, audiotapes + survey	458 patients, 61 doctors	None	African American vs White	US	Drs were more verbally dominant, less pt-centred and use a less positive affective tone with AA pts.	Observer	High (+/+)
Mosen et al. 2004	English	Quantitative, survey	570 patients	None	Spanish speaking	Paediatrics, US	Spanish speaking pts reported worse experiences with dr communication, because of bad explanation and less time.	Patient	High (+/+)
Weitzman et al. 2004	English	Qualitative, focus groups	25 patients	None	Latino	US	Barriers in communication are lack of trustworthiness, experiences with healthcare and language. Language skills of the dr are more important than ethnicity. Pts stated that assertiveness was not an option. The combination of language barrier and being not assertive is difficult.	Patient	High (+/+)
Fernandez et al. 2004	English	Quantitative, questionnaire	116 patients, 48 doctors	None	Spanish speaking	Primary care, US	Pts were more likely to report better interpersonal processes of care when their dr had a higher self-rated language ability and cultural competence.	Patient + doctor	High (+/+)
Johnson et al. 2004	English	Quantitative, interview	6.299 patients	None	Mixed	US	Hispanic and Asian pts were less likely than White and AA pts to say that the dr listened well; they understood everything, shared DM, had enough time.	Patient	Medium (+/-)
Barkin et al. 2003	English	Quantitative, questionnaire, pre-test	15 patients, 5 doctors	None	Latino	Paediatrics, US	Baseline trust and communication were high.	Patient	Low (-/-)
Cooper et al. 2003	English	Quantitative, audiotapes + questionnaire	252 patients, 31 doctors	None	African American	US	Race discordant visits were shorter and had a less pt positive effect. There were no differences in DM and satisfaction. AA pts were sensitive to interpersonal cues from the dr, because of historical and personal experiences with discrimination.	Patient + observer	Medium (-/+)

Harmsen et al. 2003	English	Quantitative, questionnaire + interviews	87 patients, 87 doctors	Kleinman et al. 1978	Mixed	GP, the Netherlands	Communication of dr with minority pts was less effective, than with pt of ethnic majority. There was more misunderstanding, more non-compliance and less mutual understanding, especially in the minority group with mixed traditional and Western cultures.	Patient + doctor	High (+/+)
Saha et al. 2003	English	Quantitative, questionnaire	6299 patients	None	Mixed	US	Ratings of dr behaviour, cultural sensitivity and dr-pt interactions were lower among Hispanic and Asian pts, than Black and White pts. Non-White pts were less satisfied with healthcare.	Patients	Medium (-/+)
Piette et al. 2003	English	Quantitative, questionnaire	752 patients	None	Mixed	Diabetes, US	AA and Hispanic pts reported better general communication. AA pts and other minorities reported better specific communication than White and Hispanic pts.	Patient	Medium (+/-)
Shapiro et al. 2003	English	Quantitative, questionnaire	107 doctors	None	Mixed	Family and internal medicine, US	Drs tented to identify serious cross-cultural problems as those that focussed on perceived pt shortcoming. Family medicine drs rated culturally competent communication as more relevant than internal medicine drs. Drs found themselves competent in intercultural communication.	Doctor	High (+/+)
Lingard et al. 2002	English	Qualitative, focus groups	29 doctors	None	Mixed	Paediatrics, Canada	Drs believed that lack of experience and knowledge about other cultures caused their communication difficulties. Drs thought that prejudice was not an issue. Drs had difficulties with using the right interview technique.	Doctor	High (+/+)
Sleath et al. 2003	English	Qualitative, audiotapes + document analyses	98 patients, 25 doctors	None	Hispanic	Family and general medicine, US	Non-Hispanic pts were more likely to give information about their antidepressants than Hispanic pts.	Observer	Low (-/-)
Bubano et al. 2003	English	Quantitative, questionnaire	62 doctors	None	Spanish speaking	Paediatrics, US	Drs experienced limitations in their language. Some drs avoid communication with pts with limited English proficiency.	Doctor	Medium (+/-)
Browner et al. 2003	English	Qualitative, interview	156 patients	None	Mexican	Prenatal care, US	Miscommunication due to medical jargon, problems of translation, problems of trust.	Patient	Medium (-/+)
Sleath et al. 2002	English	Quantitative, audiotapes +interview pt + questionnaire dr	383 patients, 27 doctors	None	Hispanic vs non-Hispanic	Primary care, US	Drs asked Hispanic pts more open-ended questions. Pts' ethnicity and language did not influence any other aspect of dr-pt communication about depression or anxiety.	Observer + patient + doctor	Medium (-/+)
Kelly et al. 2002	English	Qualitative, interview	10 doctors	None	Original inhabitants Canada	Family medicine, Canada	During pt-dr communication, drs talked less, took more time and were comfortable with silence. Pts' illnesses are not distinct from their community context: relations, culture and values are inseparable. Drs behaviour and understanding changed when dealing with ethnic different pts. Pts used an unfamiliar mode of verbal communication, for example story telling.	Doctor	High (+/+)

Van Wieringen et al. 2002	English	Mixed, video observation + interview + questionnaire	88 parents, 8 doctors	Kleinman 1980	Mixed	Primary care, the Netherlands	Ethnic minority pts more often reported problems in their relationship with the dr, they had different beliefs about health and they were less satisfied with the communication. Good relationship is necessary for mutual understanding.	Patient + doctor + observer	High (+/+)
Stevens et al. 2002	English	Mixed, interview	413 parents	None	Mixed	Paediatrics, US	Ethnic minority pts experienced poorer pt-dr communication compared to White pts, especially in restriction of freedom in choosing were to seek care.	Patient	Low (-/-)
Collins et al. 2002	English	Qualitative, focus group	13 patients	None	White vs black	Cardiology, US	Four domains of communication on pt's preferences and comfort. 1. Substance of information 2. Recommendations are inconsistent with expectations 3. Dr argumentation for extra tests failed 4. Importance of trusting their dr. Lack of substance and vagueness of information may be linked to feelings of mistrust towards dr.	Patient	High (+/+)
Sleath et al. 2001	English	Quantitative, audiotapes + questionnaire + interview	250 patients, 27 doctors	None	Hispanic vs non-Hispanic	General medicine, US	There were no ethnic differences in dr-pt communication about alternative therapies. Drs with less experience were more likely to ask pts more questions. Less pts preferred their visit to be in their primary language.	Observer + patient + doctor	High (+/+)
Rivadeneyra et al. 2000	English	Quantitative, video observation	38 patients, 19 doctors	None	English vs Spanish speaking	Primary care, US	Spanish speaking pts made fewer comments and were more ignored. Language rather than dissimilar ethnic backgrounds precipitated the differences in offers made by pts and facilitations provided by drs.	Observer	Medium (-/+)
Sleath et al. 2000	English	Quantitative, audiotapes analyses	427 patients, 27 doctors	None	Hispanic vs non-Hispanic	Family and general medicine, US	Drs were equally likely to express empathy to Hispanic and non-Hispanic pts. Drs were more likely to express positivism to non-Hispanic than to Hispanic pts.	Observer	High (+/+)
Cooper-Patrick et al. 1999	English	Quantitative, telephone interview	1861 patients, 64 doctors	None	Mixed	Primary care, US	Ethnic minority pts rated their visits with dr as less participatory than White pts.	Patient	Medium (-/+)
Morales et al. 1999	English	Quantitative, questionnaire	7.093 patients	None	Mixed	US	Latino/Spanish pts were more dissatisfied with dr communication (listening, answers to the questions, explanations, support) than Latino/English pts.	Patient	High (+/+)
David et al. 1998	English	Quantitative, questionnaire	261 patients	None	Mixed	Primary care, US	Ethnic minority pts experienced less explanation about side effects of medication, were less satisfied with care than pts of ethnic majority. Both groups experienced that the dr understands them and feel that they have enough time to communicate with the dr. A language barrier impacts negatively on pt satisfaction.	Patient	High (+/+)
Rodriguez et al. 1998	English	Qualitative, focus group	28 patients	None	Latina and Asian	US	Pts identified elements to improve the dr-pt communication in the behaviour of the dr: trust, compassion, and understanding. Pts wanted the dr to initiate discussion about abuse. Pts expressed their perspectives in culturally distinctive way.	Patient	High (+/+)

Dyregrov et al. 1997	Norwegian	Qualitative, interviews	15 doctors, 10 patients	Socio-cultural theory	Mixed	GP, Norway	Drs found it frustrating communicating with immigrants, because of different thoughts and norms, language and expectations, experience about body and pain. Difficulties with discrepancy between verbal and non-verbal communication, this made it difficult to understand the immigrants symptom description and their understanding of illness.	Patient + doctor	High (+/+)
Blöchliger et al. 1997	German	Mixed, questionnaire, focus group	314 patients	None	Mixed	GP, Switzerland	Cultural and social factors complicated communication during a dr-pt interaction and caused that drs focussed on a somatic diagnose. Most drs felt that communication problems were related to speaking a common language.	Doctor	High (+/+)
Cave et al. 1995	English	Qualitative, focus group	13 patients, 5 doctors	None	Mixed	Family medicine, US	Drs thought that understanding pt' culture better would achieve better diagnosis. Pts didn't understand why the dr asked questions about their culture. Pts found this intrusive. Barriers for the pt are: little time, no explanation, expect that the dr will know their culture; pts see Western medicine as superior. A facilitator for the pt is: trust in knowledge of the dr. Barriers for drs: time pressure, seeing pt not as an individual. Facilitators for the dr are: awareness of culture, understanding the isolation of minority pts, culturally sensitive approach.	Patient + doctor	High (+/+)
Ari et al. 1995	English	Qualitative, interview	18 mothers	None	Japanese	GP, UK	Language was a barrier in face-to-face communication. Pts found it difficult to understand colloquial expressions. Drs were unfamiliar with Japanese pt's expectations and experiences. Facilitator for the pt is when the dr writes down the keywords so they can use a dictionary at home.	Patient	Medium (-/+)
Favrat et al. 1994	French	Quantitative, questionnaire	612 patients, 20 doctors	None	Mixed	Outpatient clinic, Switzerland	Drs felt less satisfied with minority pts because of communication difficulties, but they felt that they have the same diagnostic accuracy as with other pts.	Doctor	Medium (-/+)
Krauss-Mars et al. 1994	English	Quantitative, questionnaire	40 parents	None	Mixed	Disabled care, South Africa	Language differences tend to have a negative effect on the communication. Black pts received less explanation, less possibilities to ask questions, drs didn't ask if the pt understood.	Patient	Medium (-/+)
Wilson et al. 1994	English	Quantitative, questionnaire	813 patients, 106 doctors	Kleinman 1977	Asian vs White	Psychiatry, UK	Asian and White pts registered emotional experiences equally, but communication and management differed. Pts suggested differences in the way which members of each group understood the meaning of their distressed feelings in the context of a dr visit.	Patient +doctor	Low (-/-)
Erzinger 1991	English	Qualitative, interview + audiotapes analyses	26 patients, 11 audiotapes, 20 doctors	None	Spanish speaking	US	Facilitators for the pt: describe concerns, clarify information conveyed by the dr, obtain an adequate explanation, develop a personal relationship. Facilitators for the dr: explore symptom, interpret follow-up data, adequately explain and advise, understand pt's personal situation. Success of the medical encounter is determined by how dr and pt each assist in completion of the others tasks. The dr style of paraphrasing and using the pt's exact words encourages the pt's elaboration of her concerns.	Observer + patient + doctor	High (+/+)

Wright 1983	English	Mixed, questionnaire	39 doctors	None	Asian vs English	GP, UK	Drs felt that Asian pts consulted more often and took up more time than English pts. Drs complained about Asian pts complaining about trivial matters.	Doctor	Medium (-/+)
Hooper et al. 1982	English	Quantitative, observation	150 interactions with 15 doctors	None	Mixed	Outpatient clinic, US	Dr's empathy behaviour and time spending was higher with Anglo-American pts, than with Spanish-American pts. No differences in nonverbal attention, courtesy and information giving. Cultural differences without language differences influenced the behaviour of the dr.	Observer	Medium (-/+)
Shapiro et al. 1981	English	Quantitative, audiotapes analyses	61 patients, 10 doctors	None	Hispanic vs non-Hispanic	US	Drs performed better on dimensions of rapport, explanation and ability to elicit pts feedback with the non-Hispanic English speaking pt. There were no differences in understanding the diagnosis.	Observer	High (+/+)
Kline et al. 1980	English	Quantitative, questionnaire	40 patients, 16 doctors	None	Mixed	Psychiatry, US	Latino pts were less satisfied with the help provided by the dr's specific advice. Drs thought that pts who were interviewed directly in English felt more appreciative, were more eager to return and felt better understood. This was also more satisfactory and comfortable to them.	Patient + doctor	High (+/+)
Leng et al. 2012	English	Qualitative, focus group	28 patients	None	Chinese	Oncology, US	Pts expressed dissatisfaction with the amount, reliability and comprehensibility of information. Pts didn't understand what their dr said. Language is a barrier in participating in the treatment process.	Patient	Medium (-/+)
Cox et al. 2012	English	Quantitative, video observation	405 interactions with 32 doctors	None	Mixed	Paediatrics, US	Drs communicated differently. Asian pts: fewer relationship building utterances, Latino pts: less information, AA: less engaged in DM.	Observer	Medium (-/+)
Diamond et al. 2012	English	Quantitative, questionnaire	68 doctors	None	Spanish speaking	General medicine, US	With a language barrier drs used their own language skills or an interpreter.	Doctor	Low (-/-)
Hoang et al. 2009	English	Qualitative, interviews	10 patients	None	Asian migrants	Maternity care, Australia	Pts faced language and cultural barriers which affected the communication. They experience confusion and conflicting expectations. Family was very important for migrant pt. Drs and pts have different habits.	Patient	Medium (-/+)
Simon et al. 2005	English	Quantitative, video observation	140 interactions	None	Caucasian vs minorities	Paediatric oncology, US	Caucasian pts were more successfully informed. No differences in duration of consultation. Latino pts were more openly emotional than White or AA pts.	Observer	Low (-/-)
Brugge et al. 2009	English	Qualitative, focus group	85 adults	None	Mixed	Paediatrics, US	Pt didn't separate issues of understanding from their overall narratives of experiences with healthcare and illness. Language discordant communication was an issue for low educated Cantonese pts. Pts preferred a doctor of their own language.	Patient	Medium (-/+)
Chudley et al. 2007	English	Quantitative, questionnaire	153 doctors	None	Mixed	GP, UK	Barriers in communication are: not feeling confident with pts who speak a different language, not knowing the ideas of the pt, feeling uncomfortable with exploring sensitive topics. Facilitators: awareness of their body language, understanding pt's opinions, learning about pt's cultural perspective.	Doctor	Medium (-/+)

Degan et al. 2003	Italian	Mixed, document analyses, questionnaire	8 doctors	None	Mixed	Gynaecology, Italy	The difficulties reported by drs concerned "give clinical information", "collect medical history" and "assess the symptoms". Critical moments related to their own competence concerned "gather information and symptoms" and "give therapeutic information". Compared to the knowledge of a foreign language 20.8% said that they do not know any foreign language, while others claim to know European languages.	Doctor	Medium (+/-)
Gerlach et al. 2008	German	Qualitative, focus group	30 doctors	None	Mixed	GP, Germany	Verbal communication was a major problem. Drs tried to have a non-discriminating attitude. Drs have a profound effort for empathic understanding.	Doctor	Medium (-/+)
Gerlach et al. 2009	German	Qualitative, focus group	33 patients, 30 doctors	None	Black	Family medicine, Germany	Barriers are: insufficient medical knowledge, differences in respect to importance of language and nonverbal communication, different illness models, different experiences with discrimination. Pts named the importance of medical competence of pts, insufficient empathy of drs, insufficient time management of the dr, insufficiency in valuing diversity.	Patient + doctor	High (+/+)
Gerlach et al. 2012	German	Qualitative, focus group	39 patients	None	Turkish	Germany	Most pts experienced unequal care and discrimination. Pts wanted to be seen as individuals, expressed that empathy of the dr was often missing, resulting in no trust.	Patient	Medium (-/+)
Neal et al. 2006	English	Mixed, video observation	83 videos, 11 doctors	None	South-Asian	GP, UK	White pts had more affective consultations and played a more active role, as did the dr. Drs spent less time informing and more time in asking questions with SA pts. SA fluent English speaking pts had the shortest consultations, SA non-fluent English the longest.	Observer	High (+/+)
Ward et al. 2005	English	Qualitative, focus group + interview	18 patients, 33 doctors	None	Mixed	Home/ community care, Australia	Pts experienced barriers in lack of information, cultural factors, and negative experiences. Cultural differences were a major barrier.	Patient + doctor	Medium (-/+)
Zapka et al. 2006	English	Mixed, interview	90 patients	Palmer, Donabedian & Povar 1991	Caucasian vs African American	Oncology, US	Discussion about end-of-life topics was low. Dr-pt communication occurred infrequently.	Patient	Low (-/-)
Herselman et al. 1996	English	Qualitative, interview	19 patients	None	Xhosa speaking	South Africa	Dr felt the inability to speak the pt' language, which could help him/her with better insights into the perceptions of the pt. Pts lack adequate and appropriate vocabulary. Pts tell the dr what they believe the dr wants to know. A barrier in the communication is shortage of time. Success of the process depends on the communication. Barriers are: dr's lack of knowledge and understanding of the pt, Defensiveness and unintelligible techniques that pt use to provide information, unshared meanings between drs and pts. There is an absence of fixed patterning in the dr's communication strategies.	Patient	High (+/+)
Seijo et al. 1991	English	Quantitative, observation + interview	51 patients, 51 doctors	None	Hispanic	Internal medicine, US	Language discordance between drs and pts can have effect on interaction and its outcome by leading to decreased pt information recall of the encounter and decreased pt question asking behaviour.	Observer	Medium (-/+)

*Quality assessment on content (1. Rigor 2. Relevance), + is completely, - is partly

1. Rigor is whether the method used to generate that particular piece of data is credible and trustworthy

2. Relevance is whether the article contributes to answer our research question

Abbreviations:

Dr = doctor (plural = drs)

Pt = patient (plural = pts)

GP = General practitioner

AA = African American

SA = South-Asian

DM = decision making

US = United States

UK = United Kingdom

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Chapter 4

An introduction into realist review

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Submitted

Abstract

In medical education, research reviewing the effectiveness of interventions is key. We would like to introduce readers to an increasingly popular and rather new review method: the realist review. The realist review can be used to unravel how interventions cause effect and answers the question: what works, for whom, under which circumstances and why? The effect of interventions, especially in medical education, is influenced by various factors. These factors interact with each other and with the setting in which they are implemented. Unravelling how these interactions contribute to effect is one of the main features of a realist review. This method can be used complementary to other types of reviews or as research with a more exploratory focus. The realist review method uses both qualitative and quantitative data and comes from a methodological stance that is situated between positivism and constructivism. Our experiences using this method might be helpful for other researchers and reviewers who are curious about the realist review method.

Introduction

In health professions education many researchers use interventions, such as training-programs, to gain scientific knowledge about effective education. Interventions in medical education, such as informing residents about the costs of laboratory tests, are thought to be highly complex due to the multiplicity of social and environmental factors influencing these interventions.[1] Think for example about factors such as the enthusiasm or didactic skills of the teacher, the motivation and prior knowledge of the student and the variety between training methods, i.e. lectures or workshops.

Knowledge synthesis is used to summarise results of previous research and to build theory to understand how interventions cause effect. Serving this, we would like to introduce the realist review. Although realist review's genesis lies within the field of social sciences its approach lends itself well to an education paradigm, since the effect of educational interventions, such as programs and curricula, are often the result of a complex interaction between social and other factors. Realist review as a methodological approach is increasingly popular for investigating complex interventions, and upcoming in the field of medical education. In this article we would like to indicate when, why and how a realist review can add value to scientific research based on our experiences. We will start with an example of the authors that have used this method within the context of health professions education.[2,3]

This reflective article is not intended to equip readers with sufficient skills for conducting realist synthesis. Rather, it describes the principals and fundamentals to negotiate when to consider its use in research and provides a starting point. Those who intend to conduct a realist review should read RAMESES guideline[4] and realist evaluation handbooks for a comprehensive overview.[5,6]

An example of realist review in medical education research

With increasing pressure on health systems to provide high-value, cost-conscious care, there is growing interest in training programs that produce physicians who avoid unnecessary health care services.[7,8] Educational interventions, such as informing residents about the costs of laboratory tests or supplying physicians with evidence-based guidelines for imaging services, show various results. There are examples of programs that were either very successful or absolutely ineffective in the training of physicians. Fascinated by these conflicting data, we aimed to understand how these educational interventions cause learning. For the development of educational interventions in this area it is essential to unravel its working mechanism of

these educational interventions for which we used a realist review approach.[3] In this realist review we concluded, instead of choosing one superior educational intervention, that there are a number of active ingredients, such as features of an supportive environment, that are considered essential for the training of physicians, residents, and medical students. Rather than drawing conclusions regarding the educational formats (workshop versus lecture) or length of program (6 weeks versus 2 years), we applied the realist review method in order to make comments about the importance of elements of training programs, such as knowledge transmission, reflective practice and an supportive environment. These elements are not a recipe for an effective educational intervention, but give program directors and teachers insight in how physicians should be trained to provide high-value, cost-conscious care and can be used to develop effective training programs.

What is realism?

The realist review was developed to explore the underlying causal processes of interventions in social science by Ray Pawson and Nick Tilley.[1,5,6] A realist review is a theory-driven, interpretative methodology which emerged from the paradigm of realism. Realism, as described in 1987, is "the view that theories refer to real features of the world".[9] 'Reality' here refers to whatever it is in the world (i.e., forces, structures, and so on) that causes the phenomena we perceive with our senses.[9]

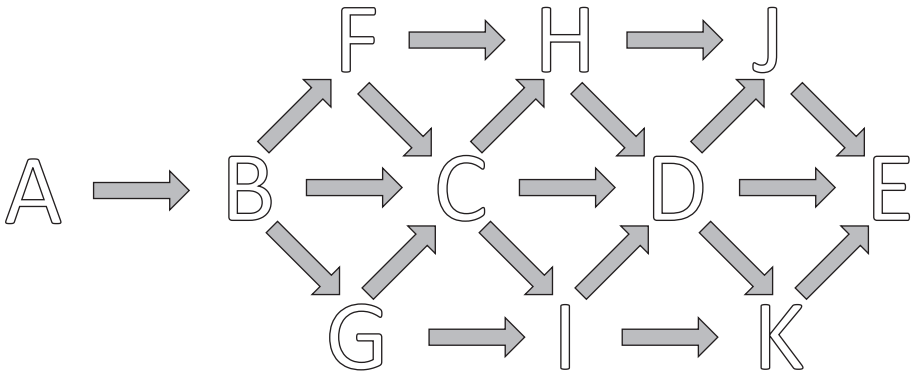
There are various forms of realism as an epistemological lens. The formal definition we utilise is that realism encourages the researcher to take note of, and acknowledge that there is, a reality that can be captured using research methods to help improve our understandings. This *real world* is influenced by our knowledge, human senses and culture, beliefs and resources, which means that everybody can interpret this real world in a different manner. Therefore, the realism philosophy has its paradigm situated between positivism ('there is a real world which we can apprehend directly through observation') and constructivism ('given that all we can know has been interpreted through human senses and the human brain, we cannot know for sure what the nature of reality is').[1]

Unravelling the 'black box'

To demonstrate the lack of insight in how interventions cause effect, we often think about the intervention as a 'black box' (see figure 1). Implementing the intervention in context (A) leads to an outcome (E). How the intervention works and how various

components of the intervention (i.e. mechanisms in realist jargon) interact to generate outcome (E) remains often unclear. Other review methods, such as the systematic review (meta-analysis), can be criticised for lacking sophistication, since it tends to focus on very specific factors or outcomes. The greatest strength of the realist review is unravelling the interaction between contextual factors, working mechanisms and effects or outcomes and understanding how interventions cause effect.[9]

Figure 1. Unravelling the 'black box'.[10]



The interactions in the black box (mechanisms) can be measured, such as amount of participating students, but can also be more hidden to the investigator, for example a concurrent teaching program with high self-study demands. This example shows that in order to see how these different mechanisms work and interact, the investigator needs to be able to identify them. In realist review, the investigator will analyse the data in order to find mechanisms. These mechanisms are recurrent interactions that are present in multiple articles.[1] A fundamental tenant of realist approaches is that it is not the intervention that causes change, but the interaction between features of program and the users who influence the mechanisms and subsequently the outcome. This also suits the general idea that curricula cannot be copy-pasted from context A to context B and have the same learning effect.

Additional value of realist review

In conducting a realist review ourselves, we found that there are several reasons to conduct one. The value of the realist review is most predominantly visible when a)

there are contradicting results in previous research regarding the effectiveness of interventions, b) heterogeneity of data exists, c) an explorative focus is desirable in order to identify why and how something works, and d) a meta-analysis is not possible and it is necessary to deconstruct or evaluate complex interventions.[1] Realist synthesis is highly synergistic to a systematic review. However, a limitation of the latter has been the orientation to hierarchies of evidence that preclude non-experimental designs.

Limitations of realist review

There are a few critical points investigators and readers should take into account. The most foundational point of critique is associated with the reproducibility of the results of a realist review.[11] Although Wong et al.[4] published a guideline for conducting and reporting realist review in a systematic order, the critique remains that the results are constructed through extensive analysis and synthesis of the data by the principle investigator and the research team, and therefore influenced by investigators. A way for authors to deal with this point of critique is to write a reflective note to reflect on their background and personal stance towards the subject. The realist review method remains in its infancy and methodological advancement seems necessary. A considerate selection of the members of the research team and their involvement in critical discussions of the analysis and synthesis are essential.

Tips from our own experiences

As with many authors embarking on a research project, we aimed to familiarise ourselves with as much theoretical and applied information as possible. With all of our intentions and training, we fully understood intentions and objectives of the realist review methods and guidelines. Although these guidelines[4-6] for realist synthesis may provide some guidance, it remains difficult how to apply them.[11] As with most forms of qualitative research, researchers are permitted flexibility and the recommended aim is not reproducibility. It is important to understand that reproducibility is unlikely between two realist syntheses. That being said, what aided our team was writing rich, reflexive notes that openly described how personal features and background might influence the research process in order to meet quality standards in this qualitative review method. We strongly suggest conducting a realist review with a highly diverse research team; debates and facilitated discussion were some of the most important activities experienced by our team and are a great contribution in

conducting rigorous research.

In our view, the realist review is an important methodological approach for understanding how education works. It can be used to complement a systematic review or as a way to analyse heterogeneous data, acknowledging the value of both quantitative and qualitative research. It will be important for researchers to continue to develop approaches for conducting, reporting and integrating realist review in answering research questions. We've learned that realist review is a methodology that, in line with realist philosophy, interacts with researcher and subject, in order to give valuable outcomes for medical education research. Conducting a realist review introduced us with a new philosophy which will be valuable for our personal learning process in the field of medical education.

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Chapter 5

Intercultural doctor-patient communication in daily outpatient care; relevant communication skills

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Submitted

Abstract

Objective

Intercultural communication between doctors and patients is often associated with misunderstandings and dissatisfaction. To develop intercultural communication specific medical education, it is important to find out which intercultural communication skills medical specialists currently apply in daily clinical consultations.

Methods

Doctor-patient consultations of Dutch doctors with non-Dutch patients were video-taped in a multi-ethnic hospital in the Netherlands. The consultations were analysed using the validated MAAS-Global assessment list in combination with intercultural communication influencing factors described in literature.

Results

In total, 39 video-taped consultations were analysed. The doctors showed to be capable of practicing many communication skills, such as listening and empathic communication behaviour. Other skills were not practiced, such as being culturally aware and checking the patient's language ability.

Conclusion

We showed that medical specialists did practice some but not all relevant intercultural communication skills and that the intercultural communication style of the doctors was mainly biomedically centred. Furthermore, we observed an overlap between intercultural and patient-centred communication.

Introduction

Effective, patient-centred communication between doctors and patients is essential for delivering high quality patient care.[1] Good communication by doctors improves health outcomes, enhances patient satisfaction, and contributes to doctors' job satisfaction.[2] In the context of a multicultural society however, effective communication could be hindered by cultural differences.[3] Intercultural communication (ICC), which in this article is defined as communication between a doctor of the dominant ethnic origin and an ethnic minority patient, potentially causes misunderstanding and reduces interpersonal interactions, which may lead to lower quality of care.[4] Napier et al. stated that "the systematic neglect of culture in health and healthcare is the single biggest barrier to the advancement of the highest standard of health worldwide".[5]

The theoretical fundaments of ICC between doctors and patients have gained attention in the last few years.[6-8] In a recent review, a conceptual framework of influencing factors in ICC is presented.[6] This framework is constructed based on 145 included articles with a variety of evidence about intercultural communication between the doctor and the patient. Relevant influencing factors of ICC such as the role of the family in a conversation, the doctor's awareness of the effects of differences in ethnical background, or the patient's expectations of a conversation with the doctor, were translated into communication skills. These skills are of great importance in daily clinical practice and hence should be implemented in medical education.[6]

The importance of the use of certain communication skills depends on the relevance of that skill in the specific context.[9,10] In general, however, professional communication requires adaptation to the specific characteristic of the patient and the situation. Therefore, different contexts, such as differences in ethnic origin between the doctor and the patient, should be explicitly addressed.[3,6,7,11,12]

While the theoretical knowledge of ICC skills and the necessity of using these skills have been established[6,8,13], several researchers, however, argue that the scientific field of ICC between doctors and patients in real practice is still too small to develop focussed training in ICC[7,14] and that feedback only does not cover the full picture of skilled medical communication.[15] It is, for example, unknown which ICC skills are being applied by doctors and how they are practiced. To develop knowledge about ICC skills, and therefore also the skills that they do not practice properly, the need has raised to further explore which of communication skills are applicable in the clinical setting and which need improvement.[3,13]

In this paper, we identify which ICC skills medical specialists use in real practice dur-

ing those moments in the medical visit in which such skills are judged to be relevant. We addressed the following research question: Which influencing factors of ICC described in literature are recognisable in doctors' communication skills in real practice?

Methods

Study design

In this observational study, doctor-patient consultations with ethnic minority patients and doctors of the Dutch ethnicity were video-recorded and analysed. The analysis focussed on the doctor's way of communicating and concentrated specifically on whether the ICC skills identified in a recent realist review were applied in daily practice.[6]

Setting and participants

Between September and December 2014, we videotaped conversations of gynaecologists, internists, urologists and orthopaedic surgeons in the outpatient clinics of the Sint Lucas Andreas hospital in Amsterdam, the Netherlands. This district teaching hospital serves an urban multi-ethnic area. Dutch doctors were asked to participate. The patients with a non-Dutch origin were included if they had an appointment for a new episode and the patient had not been seen by this doctor for a year or more. These patients could be of any origin and were not a priori selected. They were all referred by a general practitioner. Informed consent of both the doctor and the patient was requested by the first author, who then, if informed consent was obtained, installed the camera and left the room. Exclusion criteria were: presence of an interpreter, patient of Dutch ethnicity, doctor of a non-Dutch origin, a follow-up consultation or a consultation that was partly done by somebody else, for example a medical student.

Maas-Global Intercultural Communication

Since a validated observation list for ICC did not exist, we combined the MAAS-Global, a validated instrument for assessing patient-centred communication,[2;16;17] with the influencing factors of ICC found in a recent review.[6] The MAAS-Global is commonly used in medical and general practice postgraduate training programs in the Netherlands.[18] Combining the two protocols was possible because there is an overlap between the categories of the Maas-Global and those used to classify the influencing

factors in the review. The combination of the Maas-Global and the ICC-influencing factors provided a framework for coding ICC skills, which could then be observed. The resulting observational scale, the Maas-Global ICC (see Appendix A), includes 52 communication skills to be analysed on a dichotomous scale as 'present or absent' and a 4-point Likert scale to indicate the relevance of each skill for the consultation under observation. This observation and analysing is done per section of the communication, e.g. opening or exploration of reason for encounter (see Appendix A). In the results section, we report on the relevant skills which were present or absent. Because the MAAS-Global ICC is an extensive list, the result section includes the communication skills of the MAAS-Global ICC that were found to be relevant are described as absent or present in at least 40% of the consultations. Additionally, the observers were asked to add qualitative comments about the communication in general, which provided a global impression of doctors' use of communication styles.

Measures and analysis

The adapted MAAS-Global ICC was tested on face-validity within the project team, which consisted of specialists from different fields of expertise (medical, cultural competence, communication in healthcare, medical education). The first author (EP) observed and analysed all the included videotaped consultations. The videotaped consultations were also independently observed and analysed by one of four second observers (CS, LB, LR, TA), who all watched 9-10 videotaped consultations each. After the first independently observed consultation, the intraclass correlation coefficient (Cohen's kappa) was calculated and discussed between EP and each second observer. Thereafter, EP and the second observer independently scored three consultations, and once again the intraclass correlation coefficient was calculated. If the Cohen's kappa was below 0.6, the videotaped consultation and scoring were discussed to check if the observers could reach a higher level of agreement. Before discussion, the mean Cohen's kappa between the observers ranged from 0.47 to 0.59. After a discussion between the observers, the mean Cohen's kappa ranged from 0.67 to 0.82. Scoring of the videotaped consultations was analysed with SPSS 21.

After every consultation the satisfaction of the doctor about the consultation was asked. Also, the doctor had to write down if he or she had enough time for the consultation.

Ethical regulations

The study was performed according to Dutch privacy legislation. Approval of the Dutch medical education ethics board was obtained for this observational study (NVMO-ERB 355). Beforehand, all participating doctors and patients were informed about the aim and the procedure of the study. All participants signed an informed consent form before the recording of the consultation was started.

Results

In total, 18 doctors were asked to participate and 17 doctors agreed to participate. One doctor refused because he found it unfriendly to ask his oncology patients. Of these 17 doctors, 69 consecutive patients of non-Dutch origin were asked to participate. Of these patients, 41 gave informed consent. The other 28 patients refused to participate, mostly because of privacy reasons. Two of the 41 videotaped consultations were excluded, 1 because the doctor was of non-Dutch origin and one because the videotape lacked audio.

Table 1 shows the characteristics of the 39 included videotaped consultations. Furthermore, table 2 presents the relevant communications skills demonstrated by the doctors. Table 3 lists the communication skills that were not used by the doctors but that the observers considered to be relevant in the specific context of an intercultural conversation. After the consultation, all doctors noted that they were satisfied with the consultation and that they experienced to have enough time for the consultation.

Table 1. Characteristics of the video-taped consultations.

	Number of consultations (n=39)	Ethnicity (non-Western[a]/ Western[b]) n=39	Gender (M/F)	Mean age (y)	Mean length videos (min)
Patient included (%)	-	32/7 (85/15)	21/18 (54/46)	46.3	-
Specialty of the doctor[c]					
• Gynaecology & obstetrics	7	-	2/3	-	17.4
• Internal medicine	15		5/1		14.6
• Urology	5		3/0		7.8
• Orthopaedic surgery	12		4/0		13.0

[a] Afghanistan, Turkey, Morocco, Surinam, Nicaragua, Nepal, Nigeria, Cuba, Pakistan, China. [b] Poland, Great Britain, Germany, Belgium, Australia, Hungary. [c] Doctors were all of Dutch origin.

Observed communication skills (table 2)

Doctors showed a variety of ICC skills that facilitated the communication. For example, in most consultations doctors adequately employed concrete language, listening and empathic behaviour toward the patients, such as reflecting the patient's feelings and demonstrating concern. Also, doctors gave concrete explanations, for example using drawings to explain an X-ray.

Table 2. An overview of skills, present in at least 40% of the consultations: present communication skills.

Present communication skills* The doctor…….
Listens
Demonstrates reliability (being friendly and having an open attitude)
Makes appointments: who, what, when
Takes the time
Has an unprejudiced attitude
Shows empathic behaviour
Applies an adequate time schedule
Gives concrete explanations
Shows respect for the patient
Uses concrete language
Explains referral to other healthcare workers
Listens actively
Shows concern, is inviting and sincere, commiserates by means of eye contact and non-verbal behaviour, shows compassion for the patient
Commiserates with verbal reactions
Has an open attitude (shows possibilities verbal/non-verbal to give the patient space for their story)
Responds to non-verbal behaviour and keywords
Gives information in small amounts
Tries to empathise with the patient's emotions
Explains cause and relation of the complaint within the context of the expectations of the patient
Reflects on the feelings of the patient
Uses different ways to give explanations
Announces stages of the conversation
Treats the patient with care and respect during physical examination
Checks if the patient and/or relatives understand the explanation

* The skills is the table are presented from most to least present.

There was no hurry in most conversations, and most doctors had an adequate time schedule. All these present skills were considered relevant by the observers, because in this way respect, reliability and an unprejudiced attitude were shown.
In many consultations the doctors used a biomedical style of communication, in which they focussed on their own agenda with biomedically structured questions and fewer possibilities for the patient to give input.

Absent communication skills (table 3)

ICC language skills include checking the patient's language ability, which was absent in 17 consultations where it would have been relevant to apply. In 37 consultations the main language spoken was Dutch. In two it was English. Absent ICC skills, such as awareness of cultural differences, e.g. the doctor says something about treatment habits in the Netherlands or asks the patient for cultural habits for the specific disease, and adaptation of diagnosis and treatment policy to the context of the patient, e.g. the doctor asks if the prescription use of medication is possible in the situation of the patient, were considered relevant because these skills facilitate mutual understanding and respect.
The ICC skills were sometimes difficult to score, because they were elusive and not explicit. For example, the doctor did not always directly address a patient's cultural background, but tried to get insight in the patient's perspective by figuring out what the patient thought to be the cause of the complaint (e.g. pain). Also, many doctors did not check the foreknowledge of the patient about the diagnosis and treatment policy. The relevance of attention to cultural differences was emphasised in the doctor's explicit communication. For example, doctors did not take the patient's context into account when proposing a policy, such as medication use or dietary advice, and they had difficulties shifting from their biomedical communication style to the context and expectations of the patient. When the conversation was mainly biomedical, it was difficult to determine if the doctors were aware of their own cultural and professional context. In a few conversations the doctors mentioned their own cultural origin, for example by explaining how a treatment is being executed in the Netherlands. This, however, did not linearly cause doctors to pay attention to cultural differences. Summaries were not often used in the conversation, although this could have structured the conversation and it could have helped both the doctor and the patient to check if specific information was understood correctly.
Other skills that were absent but relevant lay in the field of expectation management,

showing interest in the patient's family and checking if the patient understood the information given by the doctor, which was relevant as it might have helped to clarify possible misunderstandings. An example of expectation management is exploring the patient's view on the reason for the consultation or the patient's expectation of the consultation. However, if doctors used questions aimed at clarifying the patient's expectations, which was not done in 62% but used in 38% of the consultations, this showed to facilitate the intercultural communication and direct the communication into a more patient-centred approach, depending on the way they were phrased. For example, after listening to a complex account of the patient's complaints, one doctor asked, 'what do you expect from me? Would you like me to reduce the pain, or is it something else?'

Table 3. An overview of skills, absent in at least 40% of the consultations, but were relevant within the context of these consultations: absent communication skills.

Absent communication skills* The doctor did not…..
Check expectations regarding the consultation/healthcare
Ask about the patient's feelings
Ask about the relatives' emotions
Show awareness of his or her own cultural and professional context
Check foreknowledge of the patient about diagnosis or expected policy
Summarise the patient's story
Explore the reason for the consultation, wishes and expectations
Explore reaction of information transfer to the patient's context
Demonstrate being alert to possible cultural aspects when asking for the reason for the consultation
Show awareness of cultural differences
Show to have learned from previous consultations with ethnic minority patients
Ask if the patient understood the information
Check if the patient and/or family understood the explanation
Adapt cultural differences in diagnosis and policy
Observe cultural differences
Check the language ability of the patient
React adequately to possible cultural differences

* The skills is the table are presented from most to least absent.

Discussion

In this observational study, we focussed on relevant skills of ICC of medical specialists in real practice. The medical specialists in this study proved to be capable of practicing many communication skills, such as listening, showing empathic communication behaviour and being open and respectful to the patient. Other skills were not practiced although they were relevant in the intercultural context, such as being culturally aware, checking the patient's language ability, checking if the patient understood and exploring the reason for the consultation. The communication style of the doctors was often a biomedical style.

The use of a biomedical style in these intercultural conversations is surprising, since ICC requires a patient-centred focus with specific attention to the patients' biopsychosocial needs, because of the vulnerability for misunderstandings of ethnic-minority patients.[13,19] Our study showed that the doctors did not properly apply a number of specific ICC skills, such as adapting diagnosis and treatment policy to the cultural context. However, they also did not practice certain generic communication skills, which is striking because we included medical specialist who could be expected to have learned how to practice these communication skills. This is a valuable finding, as medical specialists function as role models for postgraduate trainees.[20]

Nowadays, doctors in Western countries are taught to use a patient-centred communication (PCC) style.[8,13,19,21] PCC has similarities with ICC, such as the responsibility of the doctor for non-medical or interpersonal aspects of the communication.[22] The interpersonal aspects of care, for example trust, respect and empathy, are key determinants of patient satisfaction.[13,19] As was mentioned above, we found missing generic communication skills, such as exploring the reason for the consultation, checking if the patient understood, and expectation management. These are skills of PCC as well.[19] In an intercultural context, PCC is even more important, because the balance in the interpersonal aspects of the communication is harder to find when doctor and patient have different norms and values. ICC and PCC have not been formally integrated together in medical education, although the function of ICC and PCC are both to improve healthcare quality in similar ways and the used skills for PCC and ICC show similarities. Therefore, PCC and ICC should be incorporated in medical education, so that doctors will not have to learn two different approaches.[13]

Finally, we need to say that the complexity of ICC cannot be grasped in a list of do's and don'ts. It is not a matter of learning only one skill for ICC but of learning a complete set of skills and being able to apply these in the right way at the right time. It is

the complete set of behaviours which makes a doctor a good intercultural communicator, and communication training is not a 'one size fits all' training.[5]

Conclusion

We showed that doctors did practice some but not all the relevant ICC skills and that the intercultural communication style of the doctors was mainly biomedically centred. Hence, it is unlikely that postgraduate medical trainees will acquire all the required ICC skills merely by modelling their behaviour on the example of their clinical supervisors. Furthermore, we observed an overlap between intercultural and patient-centred communication. This overlap and the absence of skills in both these domains suggest that integrating PCC and ICC training may contribute substantially to the development of medical education for postgraduates and medical specialists.

Strengths and limitations

This observational study provided the opportunity to examine the application of ICC skills in real practice. A strength of this study was the focus on specialists instead of trainees, because medical specialists function as role models for the postgraduate trainees. Another strength was that the consultations were videotaped before they were analysed, and that the videotapes were analysed by observers from different areas of expertise, so that the data could be viewed from several perspectives. A limitation is that the study population was too small to assess differences in communication styles between the doctors.

Implications for medical education

Based on the results of our observation study of daily outpatient care and the points mentioned in the discussion, we would advise to extend the already existing communication training for postgraduate medical education with ICC-specific skills. Elaborating ICC training could include discussion of doctors' own video-consultations with peers in the presence of a communication expert. Besides, we would advise that medical specialists should also embrace the concept of lifelong learning and that they should attend communication training focussed on patient-centred communication that includes ICC.

Future research

Many elements of the Maas-Global ICC we used seemed to be relevant for communication with every patient. Future research could study if this is true, and should

further explore the overlap between ICC and PCC. Also, it appears to be important to evaluate doctors' needs for ICC skills and patients' preferences. Another future research possibility is to validate an ICC scoring list, which could facilitate research and training of ICC.

Appendix A. MAAS-Global ICC observation scale.

The Doctor……
OPENING
Checks the language ability of the patient
Checks who is the formal speaker of the family
Asks to the relatives for their connection with the patient
Listens
Reacts adequately to possible cultural differences
REASON FOR ENCOUTER
Demonstrates being alert to possible cultural aspects when asking for the reason for the consultation
Checks reasons of encounter of the relatives
Checks expectations regarding the consultation/healthcare
PHYSICAL EXAMINATION
Treats the patient with care and respect
DIAGNOSIS
Explains cause and relation of the complaint within the context of the expectations of the patient
Checks if the patient and/or relatives understood the explanation
POLICY
Adapt cultural differences in diagnosis and policy
Checks with the relatives if they understand the choice of policy
Makes appointments: who, what, when
Explains referral to other healthcare workers
EXPLORE
Explores the reason for consultation, wishes and expectations
Explores the perception of the relatives
Recognises misunderstanding caused by a language barrier
Explores the reaction of information transfer to the patient's context
Responds to non-verbal behaviour and keywords
Responds to cues/keywords which are related to cultural differences
EMOTIONS
Asks about the patient's feelings
Reflects on the feelings of the patient

Asks about the relatives' emotions
Listens actively
Tries to empathise the patient's emotions
INFORMATION TRANSFER
Checks the foreknowledge of the patient about diagnosis or expected policy
Gives information in small amounts
Gives concrete explanations
Uses concrete language
Asks if the patient understood the information
Uses different ways to give explanations
Pays attention to pronunciation
Uses attributes for explanation
SUMMARISE
Summarises the patient's story
Summarises in his own words, concise
Attempts
STRUCTURE
Applies an adequate time schedule
Takes the time
Announces stages of the conversation
EMPATHY
Shows concern, is inviting and sincere, commiserates by means of eye contact and non-verbal behaviour, shows compassion for the patient
Commiserates with verbal reactions
Observes cultural differences
Shows empathic behaviour
Has an open attitude
Shows respect for the patient
CONSULT EVALUATION
Has an unprejudiced attitude
Demonstrates reliability
Shows awareness of his or her own cultural and professional context
Shows awareness of cultural differences
Speaks more languages or words of another language
Shows to have learned from previous consultations with ethnic minority patients

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Chapter 6

How do medical specialists value their own intercultural communication behaviour? A reflective practice study

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Submitted

Abstract

Background

Intercultural communication behaviour of doctors with patients requires specific intercultural communication skills, which do not seem to be structurally implemented in medical education. It is unclear what motivates doctors to apply intercultural communication skills. We investigated how purposefully medical specialists think they practise intercultural communication and how they reflect on their own communication behaviour.

Methods

Using reflective practice, 17 medical specialists independently watched two fragments of videotapes of their own outpatient consultations: one with a native patient and one with a non-native patient. They were asked to reflect on their own communication and on challenges they experience in intercultural communication. The interviews were open coded and analysed using thematic network analysis.

Results

The participants experienced only little differences in their communication with native and non-native patients. They mainly mentioned generic communication skills, such as listening and checking if the patient understood. Many participants experienced their communication with non-native patients positively. The participants mentioned critical incidences of intercultural communication: language barriers, cultural differences, the presence of an interpreter, the role of the family and the atmosphere.

Conclusion

Despite extensive experience in intercultural communication, the participants of this study noticed hardly any differences between their own communication behaviour with native and non-native patients. This could mean that they are unaware that consultations with non-native patients might cause them to communicate differently than with native patients. The reason for this could be that medical specialists lack the skills to reflect on the process of the communication. The participants focussed on their generic communication skills rather than on specific intercultural communication skills, which could either indicate their lack of awareness, or demonstrate that practicing generic communication is more important than applying specific intercultural communication. They mentioned well-known critical incidences of intercultural communication: language barriers, cultural differences, the presence of an interpreter, the role of the family and the atmosphere. Nevertheless, their remark-

ably enthusiastic attitude overall was noteworthy.

A strategy to make doctors more aware of their intercultural communication behaviour could be a combination of experiential learning and intercultural communication training, for example a module with reflective practice.

Background

In modern multicultural society, doctors are increasingly challenged with patients from various ethnic backgrounds. This development stresses the need for effective intercultural communication (ICC) between doctors and patients. ICC has proven to be challenging for doctors,[1] which is due to differences in language, divergent expectations, different cultural norms and values, and different conceptions of the role of the family.[2-4]

ICC could be described as context-specific communication.[5,6] Previous research showed that doctors' selection of communicative actions during patient encounters is contextual and goal driven.[7] Therefore, doctors will benefit more from context-specific communication guidelines, such as guidelines for intercultural communication, and subsequent training than from generic guidelines and training.[7] Betancourt advised to teach doctors a practical framework with issues that arise due to cultural differences which may affect the doctor-patient interaction, rather than teaching about individual cultures[1], since the latter approach could reinforce stereotyping.[1,8] It is considered advisable to examine the views of doctors regarding their intercultural communication[7,9], since doctors' awareness of the patient's cultural expectations and perceptions is important in a consultation.[10]

Research on divergent expectations of doctors and patients regarding 'good communication' in intercultural consultations is scarce.[11,12] Also, little evidence is available on how purposefully medical specialists use certain communication behaviour in an intercultural context[2], while it is known that doctor-patient communication is linked to patient satisfaction and health outcomes.[13,14] Investigating the specific ICC skills required from doctors, such as asking for the language proficiency or being aware of cultural differences[2], could facilitate the integration of communication training in postgraduate medical education.[15,16]

In this study, we explored how doctors evaluated their own communication with native versus non-native patients. We also explored the critical incidences experienced by doctors during ICC. Critical incidences are segments of the communication which are experienced as challenging. We focussed on the following research questions: How do medical specialists experience ICC, how purposefully do medical specialists practice ICC and what do they identify as critical incidences within intercultural medical communication?

To gain insight into the participants' thoughts regarding their communication style, we conducted interviews based on reflective practice.[9,17,18]

Methods

Reflective practice

In this reflective practice study, interviews were held after watching videotaped consultations. Reflective practice is an introspection procedure in which videotaped situations are replayed to the participants to stimulate recall of their concurrent cognitive processes.[19] Reflective practice enables recognition of the paradigms – assumptions, frameworks and patterns of thoughts and behaviour – that shape our thinking and action.[20] Rooted in Greek philosophy, reflective practice is based on the Socratic idea of a reasoned process of weighing up the evidence to decide whether something is believed to be true or false. Socrates used a questioning technique to raise awareness among his discussion partners.

Cultural context of the research

The study was conducted in the teaching hospital OLVG in Amsterdam, the Netherlands. The OLVG hospital is known to be 'migrant friendly'[21], and around 70% of the patients were not born in the Netherlands. Consequently, the doctors in this hospital are used to intercultural communication. Interviews were conducted in Dutch, and quotes were translated into English by the researchers and checked by an English editor.

Study sample

In this study we included medical specialists. We chose medical specialists because they could be described as experienced doctors and communicators. Medical specialists were recruited by email and were asked to participate if they had previously participated in an observation study in which their conversations with native and non-native patients had been videotaped, since these videotaped consultations could be used for this reflective practice interview study. In the previous observation study, various consultations of the participants were videotaped and analysed with an intercultural communication scoring list in order to find relevant skills for intercultural communication which were practiced by the participants.[22] In the present study, all doctors were native Dutch (i.e. the participants and both their parents were born in the Netherlands).

Of each of the participants, two videotaped consultations were selected, one with a native patient and one with a non-native patient. From the database with previously videotaped consultations, the interviewer selected the first videotaped consultation

with a native Dutch patient and the first videotaped consultation with a non-native patient. The non-native patients were born in Morocco, Turkey, Nicaragua, Hungary, Australia, Belgium, Pakistan or Nigeria.

Procedure

The interviewer showed previously selected prompts from the selected videotaped consultations to elicit the participant's subjective experience in terms of beliefs, values, attitudes and considerations regarding a certain topic.[18] These prompts consisted of 5-minute fragments of the two selected videotapes. The fragments that were selected by EP concerned the part where the reason for the consultation was explored, since this is pivotal for the process of the conversation. In almost all cases this topic was dealt with in the first five minutes of the videotaped consultation.

The reflective practice interviews were held between July and August 2015. The interviews took place in the participant's own hospital. They were conducted by one interviewer (EP) and started after the participant had signed the informed consent form.

Prior to each interview, the selected 5-minute fragments were shown to the participant. The interviews were semi-structured, and contained at least the following themes: differences in communication with a native versus a non-native patient, points of improvement, and the role of the medical specialist in the conversation and critical incidences defined as important aspects of ICC pointed out by doctors.

The interviews were audiotaped and transcribed verbatim. Member checking was done by sending the participants a summary of the interview and asking for confirmation. All transcripts were anonymised. All text fragments that were considered relevant to one of the research questions were coded by attaching keywords ('codes'). To allow new insights into ICC, the coding of the interview transcripts was open and without a previously conceived coding schedule, using the program MAX-QDA. The codes were structured by means of thematic network analysis. Thematic networks are web-like illustrations that embrace the main themes of a transcript.[23] The results will be described based on the main themes.

Perspectives of the researchers and analysis

In this study, knowledge was constructed together with the participants. A constructivist approach was applied, meaning that multiple truths are constructed by and between people.[24]

The first author (EP) interviewed the participants and analysed the transcripts. Since the main researcher is a clinician, the participants could talk in medical jargon during the interviews. It was explicitly explained that during the interview nothing they said could be wrong.

The transcripts were independently analysed by another researcher with a professional background in public administration (TvR). Besides, the coding of three interviews was checked by a third researcher (CS), who has a professional background in cultural competence. All three researchers are native Dutch. To check reliability, differences in the coding and selection of fragments were discussed in an iterative process until consensus was reached about the content of the codes. This consensus was achieved after 5 transcripts. After coding 9 transcripts, no new codes were derived. The second researcher (TvR) checked the coded fragments of two further transcripts. The developed coding scheme was discussed in depth with all the authors, a communication expert and two medical education experts. The involvement of researchers with different professional backgrounds provided the opportunity to discuss the various perspectives comprised in the research theme 'intercultural communication'.

Ethical regulations

The study was performed according to Dutch privacy legislation. Approval of the Dutch medical-education ethics board was obtained for this observational study (NVMO-ERB 355). Beforehand, all participating doctors were informed about the aim and the procedure of the study. All participants signed informed consent.

Results

A convenience sample of the medical specialists' specialities was selected based on their availability and willingness to participate: gynaecology (n=4, 1M/3F), internal medicine (n=5, 5M/1F), orthopaedic surgery (n=4, 4M) and urology (n=3, 3M). All seventeen participants agreed with the summary of the interview, except for minor changes. Appendix A provides an overview of the characteristics of the patients in the videotaped consultations per interviewee.

Generic communication and intercultural communication

Many of the participants said to experience little difference in their communication with native or non-native patients. For example, they mentioned that they needed to explain the treatment plan or asked questions to define a diagnosis. In their per-

ception, the communication was influenced more by personal characteristics of the patients, such as assertiveness or educational level, than by the patient's cultural background.

I did not experience all that many differences. (C1)
They are all people, they are all patients, and they all want the same: they want to get rid of their problem and they want to be heard. (C13)

When participants did mention differences between their consultations with native and non-native patients, these were mainly focussed on the explicit challenges of intercultural communication, such as the language differences.

I try to do the same things and to treat people with respect, even if we can't understand each other. I probably gesticulate a bit more to explain things. (C9)

Awareness of participants regarding intercultural communication

Participants believed that they had an open attitude and that the background of the patient did not influence their communication. Many participants seemed to be unable to indicate what effect their communication behaviour had on the patient. For example, some participants said that they adapted their explanation of the treatment plan to the level of understanding of the patient, but they had not checked if the patient understood what they had said. However, some participants mentioned certain effects; for example, they experienced that the non-verbal behaviour of patients relaxed when they started to trust the doctor.

They see that I'm really searching for what the real problem is. And then I feel that the tension in the patient decreases. (C13)

While assuming to have an open attitude and no assumptions, some participants did not seem to recognise that a patient's culture might influence his or her communication, for example in expressing pain.

If a patient screams: 'pain everywhere!' I just think: 'yeah, right', you know. Then they are not taken seriously. If the patient just tells me what the problem is, then I will listen seriously. But if the patient makes a terrible fuss, that doesn't work for me. (C10)

Participants found it difficult to identify the expectations of patients from different cultural backgrounds. Participants thought that it is very important to ask patients about their reasons for requesting a consultation and what specific problem they wanted to discuss. However, when they reflected on their behaviour, they realised that most of the time they did not explicitly ask this question, and they considered this to be a point of improvement for their own communication.

It is important to check carefully what patients from a different background expect and what is important for them. (C4)

Patient-centred communication

Participants said that they found it important to use the same structure of their conversation when communicating with native and non-native patients. All the participants mentioned that they thought the doctor should be the leader of the conversation, which sometimes led to a directive style in their intercultural communication.

So if we repeatedly fail to establish a good communication, but the complaint of the patient is clear, then I think I rather tend to offer a solution in a paternalistic way. (C9)

On the other hand, almost all participants stated that knowing something about the patient's background is important for establishing the right diagnosis.

I sometimes also ask native Dutch patients where they originally came from. (C3)

Some participants said that they tried to adapt their communication to the patient and that, as a consequence, patients were more satisfied and felt that the doctor listened to them. They considered this equally important for both native and non-native patients.

I let the patient do most of the talking, and I only direct the communication when it is necessary. (C13)

Positive attitude

An overarching finding of the interviews was that almost all the participants were

positive about the diversity of their patient population. Participants mentioned that they found it a challenge rather than a problem to deal with patients from different cultural backgrounds.

This really is an extra challenge and also fun. Because many aspects of other cultures are much better than in the Netherlands… the involvement of people, the strong family ties and the readiness to help each other. We could certainly learn from this. (C8)

Critical incidences of intercultural communication

Language barriers

All the participants mentioned language differences as the main cause of problems in an intercultural conversation. They experienced that the patient's level of Dutch language proficiency determined the degree to which language was a barrier. The participants noted that although language differences can lead to misunderstandings, they may also lead to problems at a deeper level. One of the prominent problems mentioned by the participants was that nuances in the communication are lost.

The moment you communicate more simply, it is more difficult to express empathy. For example when asking patients about their concerns. (C7)

Participants explained that a language barrier made them adapt their communication style, for example the way they pronounced words, that they articulated more clearly, spoke more loudly or more slowly and used more non-verbal ways of communication, such as gestures.

I notice that I change the way I speak when talking to a non-native patient. I also start to speak in broken Dutch. (C7)

Also, some participants said that they repeated their own words more often and felt the need to check if the patient understood an explanation. This was found to be extremely important. In the eyes of the participants, patients had to be informed adequately before starting a treatment.

When I perform an operation, the patient has to grant permission, and therefore the patient has to really understand all the information. (C10)

Some participants said that they found it awkward or difficult to ask about a patient's language ability, because most of the time this would become evident anyway during the conversation, or patients would start the conversation saying that their language proficiency was low.

Because I assume that my estimation is correct, whereas that is of course an overestimation of myself. Sometimes I ended up being surprised, when I found out during the consultation or during a second visit that the patient spoke far better Dutch and understood me much better than I thought. (C11)

Interpreter and role of the family

The participants mentioned the use of an interpreter as an extra impediment when there was a language barrier. All participants said that a conversation with the help of an interpreter was time consuming and difficult. They found it difficult to talk to the patient through an interpreter. The participants preferred non-professional or family interpreters because they could adapt the questions more effectively to the patient's level of understanding.

It feels comfortable when the family does it. A family member can adapt the question to the situation of the patient, because, of course, they know the patient and understand what the patient comprehends and prefers. (C12)

Cultural differences

Some of the participants mentioned cultural differences as a critical aspect when communicating with non-native patients, for example when a patient refuses to look at the doctor. However, cultural differences were not considered to be as important as language barriers or levels of intelligence. Many participants did not reflect on the cultural differences and how these influenced their communication.

I think a language barrier, a real language barrier, is much more difficult than a cultural barrier. (C8)

In the case of cultural differences, religious differences were mentioned as another aspect that influenced the communication. For example, the Ramadan was mentioned several times as something that should be considered when communicating

with Muslim patients about treatment. Participants mentioned that it was important to have some knowledge of the religions of the patients that visit a hospital.

Atmosphere

The atmosphere of the conversation was considered to influence the communication. For example, the communication would be more business-like if the atmosphere was not relaxed. Participants experienced that it took a greater effort to put non-native patients at ease. Humour was mentioned as a possible solution for a strained conversation, which participants considered to be also applicable in conversations with non-native patients.

On average, it takes more time and effort to establish an easy-going conversation and a certain level of trust with a non-native patient than with a Dutch patient. (C13)

Reflection on the communication process

Participants were enthusiastic about the method of reflective practice. The participants said they recognised their communication behaviour on the videotaped consultation as representative of their communication in daily practice. They mentioned that watching the videotapes made them aware of their behaviour and some of them formulated points of improvement for themselves. These points of improvement mainly concerned aspects of generic communication, such as not paying so much attention to the computer, not interrupting the patient or giving the patient more space to tell their story before asking questions.

So yes, both in my attitude towards her at that moment - I think – as well as in my choice of words. I might have done that more calmly and I do think that would be more pleasant for the patient. (C15)

Some participants mentioned a gap between training and practice. They said that their current behaviour was a result of past intercultural communication experiences and not of any training they had received during undergraduate or postgraduate medical education. Some participants mentioned that one needed to have experience as a medical doctor to be able to be aware of one's communication behaviour.

Certainly we have been trained in many things, but in the end it still is just a conversation in the consulting room. (C5)

Discussion

The aim of this reflective practice study was to explore how medical specialists experience intercultural communication (ICC), how purposefully they practice ICC and what they identify as critical incidences within ICC. We held semi-structured interviews with participants after letting them watch their own videotaped consultations, open coded the transcripts and sorted the results thematically. The videotapes were used to facilitate the participants' reflection on their communication behaviour. Participants experienced it as valuable to watch their own videotaped consultations. The most remarkable finding was that many of the participants said they experienced hardly any differences in their communication with native or non-native patients. They mainly reflected on generic communication skills and not on intercultural communication skills. Nevertheless, the participants described the following critical incidences concerning ICC: language barriers, cultural differences, the presence of an interpreter, the role of the family and the atmosphere. At the same time, the participants expressed a remarkably enthusiastic attitude regarding communication with patients from different cultural backgrounds.

A remarkable finding is that doctors seemed to experience hardly any differences when communicating with non-native patients, except for the occasionally mentioned language barrier. The fact that doctors in our interview study found it difficult to identify differences in their own communication behaviour could indicate that they are unaware of the specific challenges of ICC and of their own communication behaviour; alternatively, it could indicate that they already are experienced intercultural communicators. The first explanation seems to be confirmed by the fact that they did not mention specific ICC skills as being important. They even found it difficult to apply specific ICC skills, such as asking for the patient's language proficiency[2,4], and they saw cultural differences as less important than language differences. Our findings are in line with the results of other researchers who found that care providers may not be aware of the challenges of cultural aspects of communication.[25,26] Besides, doctors indicated that they did not feel adequately prepared for providing effective intercultural communication.[1,27]

The second explanation, which hypothesised that the participants already were experienced intercultural communicators, might suggest that they did not view ICC as

different from communication with native patients, since they all worked in a 'migrant friendly' hospital. Silverman stated that for effective clinical communication, doctors need to know about communication and experience it themselves.[16,28] Since the medical specialists in the present study said that they had not been trained in intercultural communication, it seems more plausible that they were not completely aware of the differences in their communication with native versus non-native patients. It is therefore advisable to combine knowledge about communication and experiential learning.[16,28]

According to the five-phase model of Van den Eertwegh et al., the first step in a learning process to change communication behaviour is confrontation with one's own behaviour. In our study, however, confronting the participants with their own communication behaviour did not result in a deeper reflection on their communication behaviour. A possible explanation why watching the videotaped consultations did not make doctors express increased awareness of their own ICC behaviour, could be that they felt unable to reflect on their own communication behaviour at a deeper level. Since becoming conscious of one's own behaviour is the first step in any learning process, it is important to find ways to encourage experienced doctors to reflect openly on their own communication skills.[9,29] This reflective practice study could have provided the first steps in raising awareness regarding the communication behaviour of the participants.

The participants in our study focussed mainly on the generic communication aspects and not on the intercultural communication process. This raises the question whether the generic communication skills are more important in an intercultural context than specific intercultural communication skills. Literature on intercultural communication suggest that it has a substantial overlap with patient-centred communication[1,4,30-32], in which generic communication skills are geared to communicating with each patient as a person irrespective of their background. The results of our study could indicate that using a patient-centred communication style makes it less necessary to apply the specific intercultural communication skills.[4,31]

The participants in the present study described critical incidences concerning ICC that are well known in literature.[2,4,12] Our results add to the literature that the importance of these intercultural communication challenges is confirmed by doctors in clinical practice, which underscores the need to pay attention to these challenges in training programmes for doctors. Although this need has been established before[2,12,33], there still seems to be a gap between intercultural communication experienced by doctors

and ICC theory, which mainly focusses on the challenges and specific aspects of intercultural communication.[31,34,35]

At present, communication skills training seems to be lacking in postgraduate medical education[15,16,36], and the participants mentioned that they did not receive any formal intercultural communication training. It is therefore advisable to develop lifelong-learning concepts for communication in health care.[36] These training modules should enable participants to master the generic communication skills as well as ICC-specific skills.[7,19]

The participants in our study mentioned the additional value of having some specific knowledge about their patients' native cultures. However, it is considered more important to convey knowledge about the theories on how cultural differences influence intercultural communication than to offer specific knowledge about ethnic groups, since this might reinforce stereotyping.[1,37]

Strengths, limitations and future research

The participants included in this study all worked in the same hospital, which could limit the transferability to other hospitals. Besides, this hospital is 'migrant friendly'[21], which means that most doctors are experienced in communicating with patients from various cultural backgrounds. The participants who work in this hospital are probably already more adepted in dealing with the influences of culture on the communication than doctors who work in hospitals with a smaller variety of cultures. On the other hand, since our findings show that even extensive experiences with ICC alone do not necessarily make medical specialists aware of the differences in their communication performance, this is likely to be true as well for the broader medical specialist population. Possibly, achieving awareness of communication behaviour requires a combination of experience and ICC training, preferably in a module with reflective practice.[16] The effect of a combination of experience with non-native patients and intercultural communication training could be researched in more detail.

Although the professional background of the researchers all differed, a limitation could be the native status of the whole research team. Another possible limitation could be the method of semi-structured interviews with open questions. The participants were not directed into the reflection of their ICC behaviour, which could have caused that participants felt obliged to focus on the generic communication instead of the intercultural communication. On the other hand, this shows the focus of doctors regarding their communication even in an intercultural conversation.

Conclusion

Despite extensive experience in intercultural communication, the participants of this study noticed hardly any differences between their own communication behaviour with native and non-native patients. This could mean that they are unaware that consultations with non-native patients might cause them to communicate differently than with native patients. The reason for this could be that medical specialists lack the skills to reflect on the process of the communication. The participants focussed on their generic communication skills rather than on specific intercultural communication skills, which could either indicate their lack of awareness, or demonstrate that practicing generic communication is more important than applying specific intercultural communication. They mentioned well-known critical incidences of ICC: language barriers, cultural differences, the presence of an interpreter, the role of the family and the atmosphere. Nevertheless, their remarkably enthusiastic attitude overall was noteworthy.

Practical implications for medical education

The results of this study indicate that intercultural communication experience alone does not make a medical specialist aware of the differences between communication with native and non-native patients. Possibly, achieving awareness of communication behaviour requires a combination of experience and ICC training, rooted in patient-centred communication, preferably in a module with reflective practice.[16]

Appendix A. Overview of patient characteristics per interviewee.

Code of interview	Duration of the interview (minutes)	Patient ethnicity	Patient's age (y)	Patient's gender (M/F)	Dutch language proficiency of patients*	Informal interpreter (yes/no), (companion)
C7	31	Dutch	58	F	Good	No (with partner)
		Afghanistan	40	F	Moderate	Yes, partner
C8	33	Nicaraguan	22	F	Good	No, alone
		Dutch	79	M	Good	No (with partner)
C15	25	Dutch	65	F	Good	No (with daughter)
		Turkish	33	F	Good	No, alone
C1	31	Turkish	49	M	Moderate	No, alone
		Dutch	25	F	Good	No, alone
C5	43	Hungarian	40	F	Good	No, alone
		Dutch	50	F	Good	No, alone
C16	25	Dutch	42	F	Good	No, alone
		Turkish	39	F	Good	No, alone
C3	15	Dutch	33	F	Good	No (with partner)
		Turkish	51	F	Good	No (with partner)
C9	25	Dutch	51	F	Good	No, alone
		Australian	37	F	Bad	No, conversation in English (with partner)
C4	25	Dutch	32	F	Good	No, alone
		Nigerian	31	F	Bad	No, conversation in English (with partner and child)
C14	26	Dutch	39	F	Good	No, with child
		Turkish	51	F	Good	No, alone
C13	31	Moroccan	55	M	Good	No, alone
		Dutch	55	M	Good	No (with partner)
C17	29	Dutch	75	M	Good	No, alone
		Moroccan	21	M	Good	No, alone
C10	31	Moroccan	28	M	Moderate	No, alone
		Dutch	66	M	Good	No alone
C2	29	Dutch	36	M	Good	No, alone
		Turkish	70	M	Bad	Yes, daughter
C6	20	Dutch	61	M	Good	No, alone
		Moroccan	65	M	Moderate	No, alone
C11	27	Pakistani	76	M	Bad	Yes, daughter
		Dutch	70	F	Good	No, alone
C12	37	Dutch	49	F	Good	No, alone
		Belgian	35	F	Moderate	Yes, partner (with child)

*Based on the authors opinion and trustworthiness checked with the interviewed doctor, 100% similar.

Appendix B. List of codes derived from the transcripts.

Reflection
Unconscious behaviour
Conscious behaviour
Role of the doctor
Doctors' assumptions about patients
Verbal communication
Non-verbal communication
Structure of the conversation
Leader of the conversation
Professional attitude of the doctor
Communication in medical education
Explaining
Point of improvement
Time
Atmosphere
Personal communication
Social component of communication
Background of the patient
Different communication with native and non-native patient
Language proficiency
Interpreter
Cultural differences
Cultural diversity as part of the job
Patient-centred
Role of the family
Doctor-patient relation
Goal of the conversation
Listening
Taking the patient seriously
Consequences of language barrier
Education level of patient
Generation level of immigration of the patient
The feeling of being understood
Trust
Computer
The speed of talking
Articulation

Expectations of the patient
Greeting
Empathy
Summarising
Humour
Open attitude
Loud voice
Preferences of doctors
Respect
Misunderstanding
Medical jargon
Taking decisions
Patient satisfaction
Patient-autonomy
Reassuring the patient

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Chapter 7

Intercultural communication through the eyes of patients: experiences and preferences

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Submitted

Abstract

Background

Non-native patients have more unfulfilled informational needs and experience less mutual understanding from a native doctor than native patients. Insight into patients' preferences regarding intercultural communication is needed to develop intercultural communication training programs.

Methods

Thirty non-native patients visiting a native Dutch doctor were interviewed and relevant fragments were coded and analysed.

Results

All patients preferred a doctor with a professional patient-centred attitude regardless of the doctor's background. They mentioned mainly general communication aspects as important for the doctor to apply and seemed to be aware of their own responsibility in participating in a consultation. Unfamiliarity with the Dutch healthcare system influenced the experienced communication negatively.

Conclusion

Remarkably, patients in this study had no preferences regarding the ethnic background of the doctor. Generic communication was experienced as more important than specific intercultural communication, which underlines the marginal distinction between these two. This study provides input for the development of a more culture-sensitive, patient-centred communication training for doctors.

Background

Doctors in multi-cultural societies are increasingly confronted with patients from various ethnic backgrounds.[1] The cultural differences between doctors and patients challenge effective communication and the quality of care.[2] Cultural influence on communication is well documented.[2-5] On the other hand, there is limited literature focusing specifically on communication experiences and preferences of non-native patients.[6] To improve communication and subsequently the quality of care, insight into the communication process as experienced and preferred by these patients is needed.[7]

Doctor-patient communication and patients' perceptions of quality of care are influenced by the patient's cultural views and language proficiency.[3] Patients whose ethnic origins and cultural backgrounds are different from their doctor's evaluate the received care less positively than patients with the same background[8], mainly because of communication problems.[9,10] Previous research on medical communication experienced by non-native patients showed that they experience lower mutual understanding and less satisfaction with medical communication than native patients.[3] It is expected that better intercultural communication enhances patient involvement, satisfaction and health outcomes.[8] A key-concept in research on doctor-patient communication is patient-centred care, a paradigm defined as care focussed on the patient as a whole person with individual preferences situated within a social context.[11] One of the key elements defining patient-centred communication is that doctors adapt their communication to each patient's preferences.[12] Intercultural communication might be a combination of generic patient-centred communication skills and specific intercultural communication skills.[5,13]

Despite extensive research on patient satisfaction[7], there is a lack of insight into patients' preferences on intercultural communication.[3,6,10] Since patients' preferences are important in patient-centred communication, it is imperative to know more about non-native patients' preferences regarding intercultural doctor-patient communication.[7] Knowing patients' preferences and experiences regarding their doctors' communication in more detail could direct the development of intercultural communication training for doctors, which is not always structurally implemented in medical education.[2,14] Therefore, we focussed on two main research questions: What communication behaviours do non-native patients prefer in intercultural communication with their Dutch native doctors and how do they experience this communication?

Methods

To explore patients' preferences and experiences on intercultural medical communication, an interview study was conducted. Non-native patients were interviewed after visiting a native Dutch doctor.

Setting

Semi-structured interviews were conducted in a teaching hospital in Amsterdam, the Netherlands. This hospital was accounted as 'migrant friendly'[15] and around 70% of the patients were not born in the Netherlands. Therefore, the doctors in this hospital are used to communicating in an intercultural context. To provide a convenient sample of medical specialties, the patients were selected at the outpatient clinics of 4 departments: gynaecology, internal medicine, urology and orthopaedic surgery.

Participants

Non-native patients who visited a native Dutch medical specialist were asked to participate. Non-native patients were defined as 'patients who were not born in the Netherlands or patients with at least one parent born outside the Netherlands'. If the patient did not speak Dutch, the interview questions and answers were translated by an interpreter. This interpreter could be a family member, another healthcare worker or a professional interpreter. If the patient was accompanied by family or other people, they were also involved in the interview.

Procedure

This qualitative semi-structured interview study was performed following the consolidated criteria for reporting qualitative research (COREQ criteria).[16] The interviews, conducted in Dutch, were held between September 2015 and December 2015. Patients who met the inclusion criteria were asked to participate when they arrived at the outpatient clinic. Patients were approached in the waiting room by the interviewer and were given sufficient time to decide before signing the informed consent form. After they had consulted the medical specialist, an interview took place in a separate room. The interviews were audiotaped and transcribed verbatim. After transcription, the audiotape was erased and the transcripts were anonymised.

The interviews were semi-structured and contained at least the following themes: preferences regarding the doctor's behaviour, preferences regarding the doctor's ethnic background, experiences regarding the influence of language and cultural

differences on communication, general experiences regarding communication with doctors and, if this was difficult, their specific experience of the last consultation.

Analysis

The transcripts were coded by attaching keywords ('codes') to all text fragments that were considered relevant to one of the research questions. To allow new insights, the coding of the interview transcripts was open and without a previously conceived coding schedule, using the program MAX-QDA. The codes were structured by means of thematic network analysis.[17]

Of the 30 transcripts, 9 were analysed independently by two members of the research team. To check reliability, differences in coding and selection of fragments were discussed in an iterative process until consensus about the content of the codes was reached. In this case, consensus was reached after discussing 5 transcripts. After coding 11 transcripts no new codes were derived. The developed coding scheme was discussed in depth among all authors. Results are structured by identified themes. Per theme, first patients' preferences are presented, followed by their experiences. In the analysis we focussed on intercultural communication in general and did not differentiate per ethnic group.

Perspective of the researchers

The main researcher (EP) is a clinician with experience in the field of intercultural communication research. EP interviewed the participants and analysed the transcripts. Nine transcripts were independently analysed by another clinician with a professional background in medical education. The complete research team consisted of native Dutch experts with various professional backgrounds (cultural competence expert, psychologist and communication expert, clinician and medical education expert and medical specialist).

Ethical approval

The study was performed in line with Dutch privacy legislation. Approval of the Dutch medical-education ethics board was obtained (NVMO-ERB 557). Beforehand, all participants were informed about the aim and the procedure of the study. All participants signed informed consent.

Results

Of a total of 57 invited participants, 30 agreed to participate in the study. The most frequently mentioned reason to decline participation was lack of time. The interviews lasted between 5 and 30 minutes, depending on the participant's available time and on the level of elaboration that could be achieved in the interview. Seven patients were available for a short interview, and seven other participants were unable to reflect on the questions in a deeper way, resulting in interviews that were shorter than 10 minutes. Patients who could not reflect on the questions about their preferences regarding the intercultural communication, were asked to focus on the experiences of the last conversation with a Dutch doctor.

In total, 14 participants were accompanied by an informal interpreter. The ethnic backgrounds of the participants were Surinamese, Turkish, Moroccan, Portuguese, Indonesian, Iraqi, Irish, American and Chinese.

The characteristics of the doctor

All participants claimed that a doctor's ethnic background was not important as long as the doctor was a professional.

He needs to be a professional. Then I don't have a preference regarding his background. (interview 6)

Some participants had a clear preference for a doctor of a particular gender. Male as well as female participants said they had experienced feelings of shame when the doctor was of the opposite gender.

As a male patient I sometimes feel ashamed in front of a female doctor.
(interview 21)

On the other hand, other participants mentioned that if the doctor was a professional, the doctor's gender was not an issue. Age was another characteristic patients expressed preferences for. Some participants preferred older doctors, as they considered them to be more trustworthy.

The doctor's communication behaviour

Many participants mentioned that they felt comfortable when the doctor talked in

an accessible way, such as speaking slowly, using short sentences, explaining topics in various ways and avoiding medical jargon. Furthermore, participants considered it important that a doctor explains the diagnosis clearly, listens to patients, takes sufficient time, comforts the patient, gives advise and information to the patient and prepares the consultation beforehand. Furthermore, participants preferred a doctor to be open and friendly, with attention focussed on the patient instead of the computer.

A friendly smile or something really simple can help to create a good atmosphere between the patient and the doctor. (interview 6)

Participants said that being treated as a person and not as a disease contributed to feeling satisfied with the medical consultation. They believed that communication was facilitated by acknowledgements, such as the feeling that the doctor understood the problem, and by a feeling of being important to the doctor.

Doctors need to create a connection with their patients, the doctor needs to trust the patient, which causes the patient to have a more open attitude. (interview 30)

Professional attitude and knowledge

The attitude of the doctor was experienced as professional if he or she demonstrated having medical expertise, indicated having enough time and took the problem of the patient seriously. Participants repeatedly mentioned a doctor's medical knowledge to be important, and this was linked to the doctor's professional behaviour, indicating that participants found their doctor to be a professional if he or she was medically up-to-date and well informed about possible treatment options.

Why should a doctor need to consult a book? A doctor should know such things, otherwise I can search for my own diagnosis in Google. (interview 6)

It was frequently reported that doctors sometimes asked about their patient's cultural habits and background. Many of the participants claimed to have no problems with this. However, a few participants mentioned feelings of discomfort in those situations because they were afraid the doctor would make assumptions about them.

The doctor-patient relation

All participants mentioned that language differences were a challenge. Some participants said that communication problems were solved by the presence of an interpreter, preferably an informal interpreter.

For me, a doctor is a doctor. The problem is the language. (interview 24)

In intercultural communication, a good doctor-patient relation was mentioned as a facilitator for satisfactory communication. Some participants said that many language differences seemed to have been solved when the doctor-patient relation was established. This was based on the experience that communication was easier if the participant and the doctor knew each other, because fewer words were needed to understand each other than during the first visit.

All participants experienced positive feelings about the intercultural communication with their doctors and found it hard to come up with points of improvement for the doctor's style of communication.

I have never had a really unpleasant conversation with a doctor. (interview 11)

Patient characteristics and participation skills

Some participants spontaneously reported that patient-doctor communication was also influenced by their own behaviour. Some participants were aware that their expectations may not always be clear for doctors, which could result in miscommunication. Also, participants considered it the patient's responsibility to ask questions if they did not understand the doctor's information about a diagnosis or treatment option. Participants stated that the communication could be influenced by patient characteristics, such as their educational level, religious beliefs and age.

Knowledge of the healthcare organisation

The participants talked about the clarity of healthcare organisational aspects in the Netherlands. For example, some participants said they had initially been unaware that they needed a letter of referral from the general practitioner to see a medical specialist in the hospital. Also, a few participants were unfamiliar with the irregular availability of their doctor or the concept of a teaching hospital employing residents.

I did not just have one gynaecologist or midwife. Instead, there was a different doctor every time. (interview 13)

Discussion

The aim of this interview study was to explore non-native patients' preferences regarding the intercultural communication with their native doctor and to explore how they experienced the intercultural communication. We found that the doctor's ethnic background was considered as not important for this group of non-native patients, while a professional attitude was. Furthermore, the patients wanted the doctor to focus on them as persons rather than only on the disease. Overall, the patients were quite positive about the communication with their Dutch doctor, though a language barrier was mentioned as a major problem in an intercultural conversation. The patients stated that being acquainted with the doctor made language problems less prominent.

A remarkable result of our study was that patients had no preference regarding the doctor's ethnic background. We had expected that a doctor's ethnic background would be important to patients. Many studies report about the positive effects of language concordance between the doctor and the patient.[18,19] Since patients in our study mentioned language as the biggest barrier in a conversation with the doctor, we could imagine the positive effects of language concordance. Concerning the effect of concordance in ethnic or racial background between the doctor and the patient, various effects have been found. On the one hand, it is concluded that race concordance was not important for the communication[20], which is confirmed by the patients in this study. While on the other hand, positive effects have been found of race or ethnic concordance between the doctor and the patient.[21] The fact that this was not the case in this study could serve as an argument against the proclaimed need for categorical care, where for example Turkish doctors care for Turkish patients.[22]

To our knowledge, relevant generic communication skills identified in our study are in line with the results of Mazzi et al. on the preferences of native patients, who identified relevant communication skills for doctors, such as listening attentively, treating the patient as a person and granting enough time.[7] Although they did not investigate patient-doctor communication in an intercultural context, the similarity of the relevant communication skills could confirm that patient-centred communication is important in every context. In particular, the preference that 'patients should be treated as a person' was mentioned several times in our study. This is closely linked

to the theory of patient-centred communication, which stipulates that every patient should be approached as a whole person.[11,23] These results are also closely linked to the views expressed by the participants in our study. Considering that patient-centred communication seems to be relevant in an intercultural context, the relation between these two concepts of communication is of interest.[23] The question whether patient-centred communication alone is sufficient enough for successful intercultural communication should be investigated in more depth.[23-25]

Patient-centred communication is not only an approach to guide doctors, it also asks something of patients' participation, such explaining the reason of encounter.[25,26] In our study the non-native patients seemed to be aware of this by mentioning the need of their own participation in a conversation. In addition to the aspects of interpersonal interactions mentioned by the patients, aspects of the healthcare system are accounted for as well. As the possible overlap between intercultural communication and patient-centred communication for interpersonal relations is getting definition, this is not the case at the health care system level.[23] In intercultural communication it is important to account for the unfamiliarity of non-native patients regarding the healthcare system, which needs explicit attention in intercultural communication.[23]

The non-native patients in our study seemed to have difficulties in reflecting on their doctor's communication behaviour. They found it difficult to mention their preferences regarding the communication style of the doctor by mentioning that the communication with the doctor is most of the time good. Reflections on previous communication experiences were used to reflect on a deeper manner. Still, the participants expressed mainly positive experiences and could sparsely identify points of improvement for the communication. It could be, of course, that their doctors are already skilled intercultural communicators, since they all work in a 'migrant friendly' hospital[15], but we think that there is always room for improvement. Other studies showed that patients were mainly positive about the communication with their doctors.[27] The question remains whether patients, and especially non-native patients, have the capacity to reflect on their preferences or experiences regarding communication with their doctors at a deeper level and to formulate improvements. Gaining more understanding on this issue is particularly important since patients are seen as important stakeholders in the evaluation of healthcare communication and patients views could guide training for doctors.[28,29]

Strengths, limitations and future research

The strengths of this interview study lies in the fact that we interviewed non-native patients, since patients are the ones who need to be satisfied with the doctor's communication in order to experience good healthcare. Additionally, our sample size was large enough to ensure saturation, even though it was difficult to reflect with patients on the communication of their doctors. Besides, the various professional backgrounds of the researchers made it possible to reflect on the data from multiple perspectives. However, the interviews were performed by a Dutch interviewer, which may have influenced the responses. Further research should focus on the effect of the interviewer's cultural background, in order to find out if a deeper level of understanding could be reached more easily between a patient and an interviewer who share the same cultural background.

The results in this study show an overlap of patient-centred communication and intercultural communication. Therefore, further research could focus on the distinction between these two and their overlap, which could facilitate further development of intercultural communication education for medical curricula.

To approach and learn every aspect of each culture that could influence the medical encounter is impractical, if not impossible, and reinforce stereotyping.[2,25,28,30] We, therefore, chose to focus on the non-native patients as a group, instead of analysing the results according to their ethnic cultural background.

Conclusion

Overall, non-native patients reported positive experiences regarding the communication with native Dutch doctors, and they did not prefer a doctor of a specific ethnic background. According to them, a language barrier constituted the most important problem, which would become less pressing once a good doctor-patient relation was established. Generic communication of doctors was considered more important than specific intercultural communication, which could indicate the marginal distinction between intercultural communication and patient-centred communication. The results of this study provide input for the development of a more culture-sensitive, patient-centred communication skills training for doctors.

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Chapter 8

General discussion

Discussion

The aim of this dissertation was to unravel the process and experiences regarding intercultural communication between doctors and patients. The overall finding is that intercultural communication requires both generic communication skills and specific intercultural communication skills by the medical specialist. However, patients as well as doctors appear to focus more on generic communication skills than on specific intercultural communication skills. Furthermore, it was found that intercultural communication is not structurally implemented in medical education curriculum documents.

In this chapter, the four research questions described in chapter 1 will be answered, followed by a discussion on the overlap between intercultural communication and patient-centred communication. Then, we will reflect on intercultural communication in medical practice and medical education, present our methodological considerations and end with implications for medical practice and recommendations for further research.

Answers to the research question of this dissertation

In summary, the four main research questions (RQ) and their answers are as follows:

RQ1: *What kind of intercultural communication training in medical education is offered in the written curricula of undergraduate and postgraduate education?*

Our document analysis showed that attention to cultural diversity training is only superficially reflected in the curriculum documents of undergraduate medical education. In the postgraduate education curriculum documents, intercultural communication training is lacking. We concluded that intercultural communication is an underrepresented topic in the curriculum documents of medical education (chapter 2).

RQ2: *What are important factors in communication with non-native patients and which skills do doctors need for intercultural communication?*

Based on a realist review, we concluded that intercultural communication can be challenging due to differences in language, cultural and social differences, and doctors' assumptions. We found generic communication skills, such as active listening and explaining, to be important in intercultural communication. We also found specific communication skills for effective intercultural communication, such as awareness of one's assumptions regarding cultural differences and recognising misunderstandings caused by language differences. The generic and specific intercultural communication skills described in our review were used to further study intercultural

communication in the clinical practice (chapters 3 and 4).

RQ3: *Which intercultural communication skills do doctors currently apply in clinical consultations?*

We revealed relevant intercultural communication skills by performing an observational study based on videotaped consultations, which we scored with an observation scale adapted to the intercultural context. Doctors applied various skills, such as listening, taking time and use of practical language, such as short sentences and no medical jargon. We also scored the missing relevant intercultural communication skills (i.e. the ones which the doctors did not practice), such as checking the patient's expectations and language ability (chapter 5).

RQ4: *How do doctors and patients perceive intercultural communication in a clinical setting and how does this influence their communication?*

In a reflective practice study based on videotaped consultations, we found that doctors experienced only little differences in their intercultural communication behaviour. This could mean that they are unaware that consultations with non-native patients might cause them to communicate differently compared to consultations with native patients. They mentioned well-known critical incidences: language barriers, cultural differences, the presence of an interpreter, the role of the family and the atmosphere. Also, the enthusiastic attitude of participants regarding intercultural communication overall was noteworthy. Implications for practice could be a combination of work experience and intercultural communication training, for example a module with reflective practice (chapter 6). Furthermore, our findings of the interview study with non-native patients summarise patients' preferences regarding the intercultural communication style of Dutch doctors. Remarkably, the interviewed patients had no preferences regarding the ethnic background of the doctor. Furthermore, they considered several generic communication aspects to be important for intercultural communication, and the only aspect they experienced as a barrier in intercultural communication was a language barrier. Also, patients mentioned that their own participation was important (i.e. asking the doctor more questions), and overall they were quite satisfied with the communication with their doctor (chapter 7).

Intercultural communication and patient-centred communication

The studies in this dissertation were based on the communication between doctors and non-native Dutch patients. These studies showed that intercultural communication consists of generic communication skills and specific intercultural communica-

tion skills, suggesting that there is an overlap between intercultural communication and patient-centred communication.

Patient-centred communication is not directly linked to intercultural communication in empirical research, but it has the potential to serve as a basis for intercultural communication because of the common theoretical ground of treating each patient as a unique person. Many of the patient-centred communication principles are similar to those of intercultural communication, such as a focus on the patient as a unique person and building a trusting relationship.[1,2] Based on the studies of this dissertation, it seems helpful to approach intercultural communication as a concept within patient-centred communication instead of treating both as two different concepts. A discussion in this field is to what extent intercultural communication differs from generic, patient-centred communication. We found that patients and doctors prefer patient-centred communication and that this resulted in satisfactory communication for both parties (chapter 6 and 7).

Originally, in 1969 Balint coined the belief that each patient "has to be understood as a human being".[3] Later, patient-centred communication was described as follows: "The physician tries to enter a patient's world, to see the illness through the patient's eyes."[4] The most extensive description of patient-centredness is given by Stewart et al., whose patient-centred model includes six components: (1) exploring both the disease and the illness experience, (2) understanding the whole person, (3) finding common ground regarding management, (4) incorporating prevention and health promotion, (5) enhancing doctor-patient relationship, and (6) being realistic about personal limitations and issues such as available time and resources.[5]

In literature, the opposite of patient-centred communication is based on the biomedical model. This model incorporates the term paternalism, which could also be called doctor-centred.[6] A patient-centred doctor feels responsible for non-medical aspects of the patient's problem, which is more an individual entity than a disease entity. This means that a doctor who applies patient-centred communication focuses on the patient and his or her thoughts, questions, beliefs, preferences and abilities, instead of the medical content only.[7] Patient-centred communication is accomplished when doctor and patient reach common ground, looking through each other's eyes.[1] The doctor and the patient mutually engage in an interactive process, sharing with one another information, preferences and decisions.[8,9]

Intercultural medical communication describes a set of skills that enables a doctor to respectfully elicit from the patient and family the information needed to make an

accurate diagnosis and to negotiate mutually satisfactory goals for treatment. The doctor asks questions that build the trust that is necessary for the patient to confide in the doctor.[2] This is similar to the description of a patient-centred conversation in which the professional has knowledge about healthcare, but the patient is the 'expert' in his or her life history, life style and social environment.[10] Many studies have found positive effects of patient-centred communication, such as confidence in doctors, a greater likelihood of following recommendations[11] and less use of (unnecessary) diagnostic tests[12,13], increased patient satisfaction and more efficient practice.[14,15] It is therefore of great importance to also use a patient-centred approach in intercultural conversations. This will promote communicating on equal terms and avoid stigmatisation, since an individual focus is applied for each patient independently of his or her ethnic background.[2]

The similarities between patient-centred communication and intercultural communication lie in the area of the generic communication skills, such as exploration and showing empathy. These generic communication skills are the gateway to understanding a patient's needs, values, and preferences. Doctors proving to be skilled at intercultural communication expand this generic repertoire to include skills that are especially useful in intercultural interactions, such as asking about the patient's language ability.[2] In both concepts, equality between a doctor and a patient is promoted as ideal.[6,16]

The studies of this dissertation underline the proposition that intercultural communication can be seen as a special component of patient-centred communication, which, for example, means that existing patient-centred communication education programmes might be extended with specific intercultural communication skills.[17] Taking patient-centred communication as the basis could stimulate more attention to the specific skills for effective intercultural communication, since the generic intercultural communication skills are similar to the patient-centred communication skills. Contrary to this view, Saha et al.[6] concluded that, while there is a substantial overlap between the patient-centred approach and cultural competence, the emphasis of these two concepts is different. Saha et al. advised that intercultural communication and patient-centred communication should be understood as two different concepts. They suggest that integrating the concepts of patient-centredness with cultural competence could increase disparities, because it would preclude adequate attention to minorities and disadvantaged groups.[6]

The question that arises is what are the advantages and disadvantages of keeping

these two concepts separate or merging them completely? A disadvantage of keeping the two concepts separate is that focussing on intercultural communication alone may suggest that specific knowledge about specific ethnic groups is needed to overcome the challenges of intercultural communication and may imply that the focus is not on the patient as a person.[17,18] However an advantage, mentioned by Saha et al.[6], could be that these concepts are not formally intertwined and that keeping the concepts separate will duplicate efforts. They concede that cultural competence has always contained the core principles of patient-centred healthcare, especially at the level of interpersonal interaction, which was confirmed in the studies of this dissertation (chapter 6 and 7).

In line with our findings, Teal et al.[18], argued that to be a culturally competent communicator, a doctor must embrace patient-centred communication. They developed a model in which culturally competent communication overlaps with patient-centred communication, while they identified specific communication issues in which cultural differences may become manifest. Since Teal et al. did not include language differences in their intercultural communication model, it differs substantially from our model. The studies in our dissertation showed that a language barrier is one of the biggest challenges in intercultural communication (chapter 3, 5, 6 and 7).

Finally, the results of the studies in this dissertation are also in line with the patient-centred model of Mead and Bower.[7] In this model, the factors which influence patient-centred communication include ethnicity. Also, cultural norms are defined in this model as influencing factors of the doctor and the patient.[7] One could argue that Mead and Bower integrated cultural aspects into their patient-centred communication model. In contrast to our model (figure 1), however, the model of Mead and Bower does not display an explicit role of intercultural communication.

In summary, while the objectives of the three mentioned patient-centred communication models are subscribed[6,7,18], our model (figure 1) has the advantage that it includes language differences, integrates intercultural communication and patient-centred communication and pays due attention to the specific intercultural aspects of doctor-patient communication.

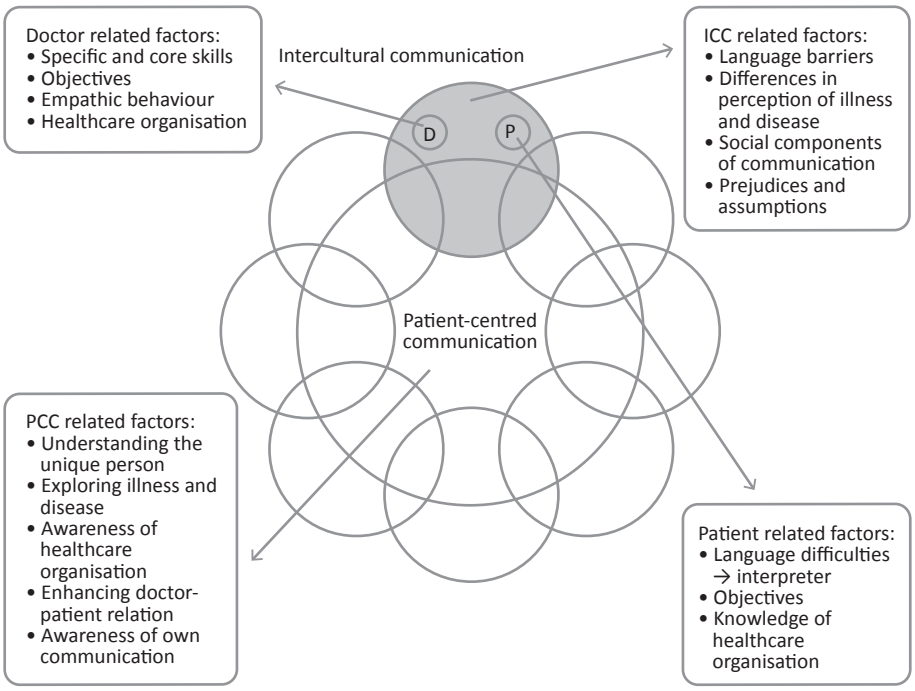
Furthermore, the studies in this dissertation showed an overlap between intercultural communication and patient-centred communication (chapter 3, 5, 6 and 7) and that treating the patient as a person is preferred by doctors and ethnic minority patients (chapter 6 and 7). We therefore propose to integrate the concepts of intercultural communication and patient-centred communication (see conceptual

model in figure 1). In this way, training programmes can pay adequate attention to communication with non-native patients without requiring much extra effort from doctors. This is relevant, since there is little spare time in the medical curricula, and intercultural communication as such has no structural place yet in the medical curricula (chapter 2). Consequently, communication training should focus on generic communication skills and on awareness of cultural and social issues. In line with this, Saha et al. stated that patient-centred communication training needs to add explicit attention to the needs of ethnic minority patients.[6] One could think of these as universal human beliefs, needs, and traits.[2] Besides, this will facilitate the development of communication curricula for postgraduate medical education and beyond.

Assuming that intercultural communication and patient-centred communication are overlapping concepts (figure 1), the question arises if doctors who apply a patient-centred approach are also skilled in intercultural communication. The general concept of patient-centred communication does help in acknowledging diversity among all patients. This is based on the interpersonal level of intercultural communication. However, if we translate this to the organisational level of a healthcare organisation, the concept of patient-centredness does not seem to be the solution for healthcare inequalities, because not all services are aligned to meet all patients' needs.[6,19] Although in this dissertation some patients and doctors commented on the influence of the Dutch healthcare system on the quality of the communication (chapter 6 and 7), the focus of this dissertation was on the process of the communication itself rather than on the organisation of the healthcare system. Thus, at the level of the healthcare organisation applying a patient-centred approach will not definitely guarantee adequate intercultural communication. Considering that patient-centred communication is the key to building common ground for a meaningful dialogue at the interpersonal level, the above-mentioned question, i.e. doctors who apply a patient-centred approach are also accomplished in intercultural communication, could be confirmed.

Based on the studies in this dissertation and on previous communication models, intercultural or otherwise, in figure 1 we present a conceptual model of intercultural medical communication. This model shows the integration of intercultural communication and patient-centred communication and gives an overview of the doctor- and patient-related factors found in this dissertation relevant for intercultural communication, and also the factors related to intercultural communication and patient-centred communication.

Figure 1. Conceptual model for incorporating intercultural communication into patient-centred communication.*



*The intercultural context could be changed into various contexts, such as a context in which the doctor communicates with children as patients or with elderly patients.

ICC = intercultural communication; PCC = patient-centred communication

Intercultural communication in medical practice

Since effective communication is subjective and fluctuates over time, one of the ways to investigate communication is by means of observational studies which are based on real practice. Schouten et al.[20] performed a review based on studies where intercultural communication was audio- or videotaped. They concluded that the studies did not relate communication behaviour to possible culture-related variables, nor did they assess the effect of differences in intercultural medical communication. It was therefore advised to research intercultural communication in a more qualitative way.[20]

Chapter 5 presents the results of the analysis of videotaped consultations. In this qualitative observation study we showed that doctors practise many generic com-

munication skills, such as listening and explaining. However, the specific intercultural communication skills, such as asking about the patient's language ability, were applied less often, even when found to be relevant in a specific context.

Since communication is a two-way process, perceptions and preferences of both doctors and patients need to be discussed. We performed two interview studies, one with patients (chapter 7) and one with doctors (chapter 6). The results showed that non-native patients do not have preferences regarding the ethnic background of the doctor. The preferences they do have are based on personal characteristics and behaviour of doctors. A doctor should, for example, be well-prepared and not too young (chapter 7). Doctors, on the other hand, showed a remarkably enthusiastic attitude regarding intercultural communication (chapter 6), which contrasts with daily news and many studies showing obstacles and timidity concerning intercultural communication.[21] Nevertheless, we found that doctors could be unaware of the challenging aspects of intercultural communication, such as differences in perception of illness and health, which might cause them to communicate less effectively with non-native patients than with native patients (chapter 6).

Although intercultural medical communication has gained increasing interest during the last decade, it has still not been properly implemented in medical education. In literature on intercultural communication, most debates focussed on the importance of transferring knowledge. Previously, intercultural communication training was focussed on transferring cultural knowledge about specific ethnic groups[18,19,22], whereas nowadays the emphasis is on the danger that providing knowledge might reinforce stereotyping.[17,23] The type of knowledge that is required for effective intercultural communication remains an ongoing issue of debate. It is considered more important to provide knowledge about theories regarding the mechanisms that influence intercultural communication than to convey specific knowledge about ethnic groups.[17,19,23]

The findings of the studies in this dissertation could be interpreted in two ways. On the one hand, we concluded that specific attention to the ethnic background of the patient is not preferred as long as the doctor uses a patient-centred approach (chapter 6 and 7). On the other hand, however, we mentioned that, for example, being able to speak a few words in the languages that are most common among one's patients would facilitate the communication (chapter 3, 5 and 7). This could be interpreted as the necessity of specific knowledge per ethnicity.

Although this knowledge can be helpful, the suggestion that members of particular

ethnic groups behave in characteristic ways may lead to stereotypic oversimplification. Nowadays, literature concludes that it is impractical, if not impossible, to learn every aspect of each culture that could influence the medical encounter. This may also prevent in-depth exploration of the interrelated social, political, and economic factors that combine to influence patients' behaviour.[1,17,18] For example, chapter 6 and 7 indicated that communication is also influenced by educational level and level of healthcare literacy. Ethnic groups are very heterogeneous, and individual members manifest the typical traits of their culture in different degrees, which makes it difficult to approach all the members of a particular culture in the same way.[1,17,18]

Another argument against gaining specific knowledge of ethnic groups is that the patient is an expert on his own culture and background.[1,7] Hence, a physician who recognises a potential intercultural communication challenge can explore the issue further by inquiring about the patient's own beliefs or preferences. This supports the idea of integrating intercultural communication and patient-centred communication, but it requires the doctor to be able to reflect and recognise possible communication challenges or misunderstandings.[24] The interviews with doctors (chapter 6) showed that recognising these occasions cannot yet be taken for granted. Summarising, each patient's situation is unique and is influenced by personal and social factors as well as by culture and ethnicity. In addition, even if the doctor does have some knowledge of the patient's cultural beliefs, this does not mean that it is possible for the doctor to predict that person's behaviour or preferences.[1] Therefore, it remains of paramount importance to treat each patient as a unique person, irrespective of his or her cultural background, which underscores the importance of integrating intercultural communication in a patient-centred approach.

Cultural and general communication training in medical education

In medical education, intercultural communication is seen as a part of cultural competence training.[19,25] Evidence shows that patients whose doctors were trained in cultural competencies, including intercultural communication, are generally more satisfied with their doctors.[26] Our studies showed that cultural diversity among patients presents doctors with challenges, such as the need to pay specific attention to the family (chapter 3, 5, 6 and 7). Therefore, intercultural communication training is needed in medical education.[17,27]

We assessed the current formal status of cultural diversity training in medical education, using the Netherlands as a case example because of the high level of migration

to the Netherlands and because the Dutch formal national curriculum documents have been updated recently.[28] An analysis of these documents revealed that cultural diversity is an underrepresented topic in the curriculum documents, which form the basis for medical training (chapter 2).

A change for the better has been initiated with the revision of the CanMEDS 2015, in which the concept of cultural competence is now made explicit (i.e. 'conduct an interview demonstrating cultural awareness' and 'communicating with cultural awareness and sensitivity').[29] However, to safeguard adequate attention for intercultural communication in medical education, it is necessary that generic communication, such as patient-centred communication, is anchored in medical education. Also, there seems to be an overall absence of generic communication training during postgraduate medical education or later.[30,31] Residents and medical specialists report to be insufficiently competent to communicate adequately, and they feel insecure about communicating with difficult patients, for example with non-native patients.[32,33] These findings about the lack of generic communication training underscore the need for developing communication curricula for postgraduate medical education.

The current focus on competency-based education includes the competence of good clinical communication.[29] Communication is a clinical skill which is not only based on personality and experience.[10,34] There is evidence that clinical communication can be taught, which is demonstrated by the positive effects of communication training at all levels of medical education, among specialists and general practitioners alike. This is important, since most communication training is developed in general practice.[35]

It has been demonstrated that there is a gap between what medical students learn about clinical communication and what they experience in practice. Many hospitals offer short training modules on communication skills, but they are not structurally supported and many doctors are unaware of their own communication skills.[35] Since teaching knowledge about communication alone does not necessarily make a good communicator, experiential learning is required for developing communication skills. The combination of knowledge and experiential learning leads to actual change in communication behaviour.[29,35-37] Van den Eertwegh et al. found that there are five stages in a doctor's learning process regarding communication, i.e. confrontation, becoming conscious, searching for alternative behaviour, personalisation and internalization. The last two steps of this model are found to be difficult to handle in hospital settings, where feedback is focussed on medical context rather than on communication.[24]

One could state that the current medical curricula failed to encourage sufficient self-awareness in docters[38], which is perhaps even more important in an intercultural conversation. In chapter 6, where reflective practice is used to make doctors reflect on their communication behaviour, a first start is made in raising doctors' self-awareness regarding their communication behaviour. The participating doctors endorsed training based on their own videotaped consultations, since the confrontation may have helped them to increase their self-awareness. It is like having a camera on our shoulder that gives feedback on how we come across when we speak and how the other may have understood what we tried to say.[39] Therefore, future professionals should not only focus on knowledge about communication but also on self-awareness[38,40] and reflexivity.[40] Communication education could be embraced as part of personal development in a lifelong learning model, rather than conceived as training standardised communication skills.[24]

Methodological considerations

In this dissertation, intercultural communication was investigated by applying several methods. A strength of the entire dissertation is that intercultural communication was explored from multiple perspectives. The first research question gave us the opportunity to analyse all the curriculum documents of under- and postgraduate medical education and provided an overview of the status these documents gave to intercultural communication (chapter 2). A limitation of this method is that such documents do not need to reflect the actual frequency and quality of intercultural communication training in medical education. However, the fact that intercultural communication was not even mentioned will certainly not help to ensure adequate attention to this topic in educational practice.

To answer the second research question, we used a realist review method (chapter 3). This method is quite new in medical education research, and our intensive use of and insight into this method gave us the opportunity to write an eye opener manuscript about the subject (chapter 4). Writing this manuscript helped us to gain deeper understanding of how to apply the realist review. Its strength lies in the systematic search, the broad inclusion of data (34.000 articles) and the possibility to search for mechanisms of the communication process.

The third research question was answered by means of an observational study based on videotaped consultations, which gave us the opportunity to formulate relevant intercultural communication skills (chapter 5). A strength of this study was the use of

an intercultural communication scoring list based on our earlier findings. Although this intercultural communication list was not validated, it was constructed on a validated communication assessment list (MAAS-Global[41,42]). Besides, it is important to realise that such observational lists are reductionist to the extent that they do not take proper account of the non-explicit aspects of intercultural communication. The validation of such a list and the influence of the non-explicit aspects of communication need to be explored further.

For the fourth research question, we started with a reflective practice method based on videotaped consultations to interview doctors about their experiences of and thoughts about intercultural communication (chapter 6). A strength of reflective practice is that doctors do not have to recall their communication behaviour, because they have a videotaped consultation as an example. It is evident that this reflective practice resembles the first steps of learning communication skills as described by Van den Eertwegh et al.[24] An additional thought is that reflective practice based on one's own videotaped consultations could also be relevant for communication training for doctors. The effect of such a training needs to be explored in more detail.

Secondly, to answer the fourth research question from the patient's perspective, interviews were held with patients. This gave us the opportunity to check if the skills we observed in the observational study and the skills mentioned in the reflective practice study were compatible with the preferences of patients. It was, however, difficult to make patients with a different ethnic background reflect more deeply on the communication behaviour of doctors. The patients seemed to have difficulties with reflection on the communication process itself. It should be further explored, for example with vignettes or observational studies, if patients can actually reflect on communication itself when it concerns their own health, or at least future studies should search for methods that make it easier for patients to indicate their preferences. Besides, for a constructivist paradigm it is imperative to find out whether the outcomes of the present research were influenced by the ethnic background of the interviewer.

Nowadays, different outcomes of communication research are frequently discussed.[43] In this dissertation, the barriers and facilitators were used as determinants of the communication process, but this was not to investigate quality of communication or the effects on quality of care.[44] The effect of intercultural communication and its training remains to be studied further.

The constructivist perspective of the researcher tended to focus on qualitative re-

search. Introducing quantitative aspects of research as well could have been valuable, for example for analysing the frequency of specific skills or for other further research, such as assessing the effectiveness of intercultural communication training. Due to the paradigm of this constructivist approach, multiple truths have been constructed by and between people.[45] To view the topic from various perspectives, we composed a research team of persons with various professional backgrounds, such as a medical specialist, experts in medical education, an expert in healthcare communication, and an expert in cultural competence.

A possible limitation could be that the studies in this dissertation were situated in a single-centre hospital.[46,47] However, we tried to use terms and definitions that are generalisable to other contexts, and we tried to be aware of possible pitfalls, such as non-generalisable data. We tried to ensure a representative sample of doctors and patients by means of random inclusion. What needs to be noted is that the studies of this dissertation were performed in a 'migrant friendly' hospital.[46,47] This could have biased the results, since all the doctors who participated in the studies are probably more experienced and open-minded regarding the diverse patient population entering such a hospital. Representativeness was attained by including a convenience sample of specialties, experience, age groups and gender. We therefore think that our proposed conceptual framework is applicable in various hospital settings around the world.

Implications and recommendations

Implications for the development of intercultural communication training in medical education:

- More attention and debate are needed regarding intercultural communication training for postgraduate medical education and medical specialists
- Develop a clear view on the content of intercultural communication in medical education
- Provide adequate descriptions, such as teaching objectives (what and how), of intercultural communication training in the medical education curriculum documents
- Describe the methods and evaluation of intercultural communication training clearly in the formal documents of medical education
- Implement specific intercultural communication skills in patient-centred communication training

- Ensure that intercultural communication training is based on generic communication skills and specific communication skills
- Provide intercultural communication training for undergraduates, postgraduates and medical specialists
- Include feedback on videotaped consultations in intercultural communication training programmes

Implications for doctors in practice based on the specific communication skills

- Make use of the positive influence of relationship-building, for example, learn a few words of the most common languages spoken by your patients
- Communicate in a patient-centred way, which stimulates participation of the patient
- Be aware of the effects of ethnic differences on communication by showing interest in the patient and being open to their different views and perceptions of illness
- Overcome language barriers by arranging an interpreter
- Check the involvement of the family of the patient in every consultation
- Explore the differences in expectations due to differences in ethnic background
- Try to reflect on the process of your communication with patients from different ethnic backgrounds
- Try to avoid stigmatisation and treat all patients as individuals
- Stimulate reflective practice in your specialty to create an open attitude regarding doctor-patient communication in practice

Implications for future research

A topic for further intercultural communication research could be the value of comparing video observations of consultations with native and non-native patients to find similarities in patient-centred communication and intercultural communication (for example on empathic cues, or finding out the hidden reason for a consultation, how to give information to patients and checking understanding). Also, the overlap of patient-centred communication and intercultural communication could be investigated further in clinical practice, for example based on the model developed in this dissertation. A possibility would be to set up a trial in which groups of participants receive different forms of communication training. For analysing the effects of such a training, videotaped observations can serve as a basis.

For the assessment of intercultural communication skills it is necessary to validate an observational scoring list. Furthermore, curriculum guidelines should be developed in order to implement both intercultural communication and patient-centred communication more structurally in medical education. Once the basis of intercultural communication is anchored in the curricula, it is easier to adapt the concept into training and subsequently into clinical practice. Finally, it would be interesting to investigate if working in a multicultural or multi-ethnic hospital makes doctors better skilled intercultural or even patient-centred communicators.

Concluding remarks

This dissertation clarifies what should be integrated into the medical curricula of at least postgraduate medical education regarding intercultural communication. A conceptual model is proposed in which intercultural communication is incorporated into patient-centred communication and which can serve as a framework for the development of intercultural communication training programmes.

Each patient needs be treated as an idiosyncratic person living in his or her own personal context. Moreover, in an increasingly multi-cultural and multi-ethnic world, good and effective intercultural doctor-patient communication is an indispensable professional competence that needs to be acquired and developed professionally, and this process needs to be supported by structured and dedicated training programmes.

Reflection of the author

Chapter 1 started with a reflection on my own experiences in intercultural communication between a doctor and a patient. After finishing this dissertation, I would change a few things in my intercultural communication behaviour in practice. First, I think I would try to be more aware of my assumptions regarding patients from different ethnic backgrounds. Second, in this case, I would try to apply the specific intercultural communication skills in more detail, such as involving the family in the conversation to gain more insights into the situation of the patient. Third, and most important in my opinion, I would approach each patient as a person and not primarily as the representation of a disease.

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Summary

The concept of this dissertation is intercultural communication between doctors and patients. In chapter 1, this concept is introduced, discussing the background as well as the presention of the dissertation's problem statement, its aim and its research questions.

Due to growing global mobility, migration and international teamwork, attention to intercultural communication is of increasing significance for healthcare. Culture could be seen as a socially transmitted pattern of shared meanings by which people communicate and develop their own knowledge and attitude about life. It includes how we interpret the world and how this is valued by us. The cultural background of communicators plays a major role in the process of communication because of different habits, values, expectations, and perceptions. Knowledge about other cultures alone is not enough to generate effective intercultural communicators. Generic communication skills, behaviour and attitudes are also indicated as necessary for effective intercultural communication, and this is where doctors struggle in actual practice.

Nowadays medical education is based on competency training. Communication is seen as one of the core competencies of a good doctor. Communication training is often limited in time, not integrated in the curriculum and scarcely contextualised. Although the need for intercultural communication education in medical curricula is well accepted in many Western countries, there is no consensus on the most effective method for achieving the right balance between attitudes, knowledge and skills. The aim of this dissertation is to explore intercultural medical communication by addressing the following research questions: 1) What kind of intercultural communication training in medical education is offered in the written curricula of undergraduate and postgraduate education?; 2) What are important factors in communication with non-native patients and which skills do doctors need to apply to practice effective intercultural communication?; 3) Which intercultural communication skills do doctors currently apply in clinical consultations?; 4) How do doctors and patients perceive intercultural communication in a clinical setting and how does this influence their communication?

A constructivist, socio-cultural lens serves as an overarching theoretical perspective in this dissertation. Each chapter focusses on intercultural communication from a different viewpoint, i.e. literature, observers, doctors and patients, aiming to raise understanding about its applicability for training in medical education. Together, the

chapters form a stepwise uncovering – though not exhaustive – of intercultural communication between doctors and patients.

In chapter 2, a document analysis was used as a starting point for this dissertation. This document analysis provided an impression of the formal status of cultural diversity, including intercultural communication in medical education in a multi-ethnic country. We discovered that only half of all strategic curriculum documents contained references to cultural diversity training. The most comprehensive description about cultural diversity was found in the blueprint for undergraduate medical education. In the postgraduate curriculum documents, attention to cultural diversity differed among specialties and was mainly superficial. The absence of a systematic sequence of training objectives, methods and evaluation is remarkable while this is regarded as important for adequate curriculum design. We concluded that despite public recognition, this recognition alone has not been sufficient to ensure adequate attention to cultural diversity training in medical curricula of a newly diverse country like the Netherlands. This study could help to raise awareness among curriculum designers and could give leads for the development of a cultural competent curriculum.

Chapters 3 and 4 are based on a realist review method. In chapter 3 a realist review was performed to explore how intercultural communication works. In chapter 4 an 'eye opener' article describes the pitfalls and our own experiences of the realist review method. A realist review summarises research based on the realist philosophy. The formal definition is that realism encourages the researcher to take note of, and acknowledge that there is a reality that can be captured using research methods that help improve our understandings. The realist review can be used to unravel how interventions cause effect. It aims to answer the question: What works, for whom, under which circumstances and why?
In chapter 3, a realist review is performed aiming to summarise the current knowledge on the factors that influence intercultural communication and to explore the mechanisms through which these factors have their effect on intercultural communication. By using a realist synthesis, it was possible to include a wide range of papers and to explore the context, mechanisms and outcomes in each of the included articles. From a total of 145 included articles, we derived four communication challenges (contextual factors), several objectives and communication skills (mechanisms) and constituted barriers or facilitators, respectively, for intercultural communication

(outcomes). The intercultural communication skills described, were interpreted as being either generic or specific. Reflecting on our research question, a framework that clarifies which skills should be trained to enable doctors to deal with each of the challenges of intercultural communication was developed. The results of this realist review were used as a framework for the subsequent studies of this dissertation.

Chapter 5 addresses intercultural communication skills in daily outpatient care. In this observational study, we focussed on relevant skills of intercultural communication of medical specialists in daily practice. In total, 39 videotaped consultations were analysed using the validated MAAS-Global assessment scale combined with 'intercultural communication influencing factors' which are described in chapter 3. In this study, the medical specialists proved to be capable of practicing many communication skills, such as listening, showing empathic communication behaviour and being open and respectful to the patient. Surprisingly, skills that are relevant in the intercultural context, such as being culturally aware, checking the patient's language ability, checking if the patient understood and exploring the reason for the consultation, were not practiced. The communication style of the doctors was often biomedical. We concluded that doctors did practice some communication skills, but not all skills relevant in an intercultural communication context. Furthermore, we observed an overlap between intercultural and patient-centred communication. Implications for practice could be to implement the relevant intercultural communication skills into the existing patient-centred communication training.

The aim of chapter 6, a reflective practice interview study, was to explore how medical specialists experience intercultural communication, how purposefully they practice intercultural communication behaviour and what they identify as critical incidences within intercultural communication. Seventeen semi-structured interviews were conducted with medical specialists of the departments of gynaecology, urology, internal medicine and orthopaedic surgery after watching two of their own videotaped consultations. One of the videotaped consultations was with a Dutch patient and one with a non-native Dutch patient. The videotapes were used as examples for the doctors for the reflection on their communication. The doctors experienced it as valuable to watch their own videotaped consultations. The most remarkable finding was that many of the doctors said to experience little difference in their communication with native and non-native patients. They mainly reflected on the generic communi-

cation skills and not on the intercultural communication skills. Also, the enthusiastic attitude of the doctors regarding intercultural communication overall was noteworthy. The doctors described the following well-known critical incidences concerning intercultural communication: language barriers, cultural differences, the presence of an interpreter, the role of the family and the atmosphere. Also, doctors preferred having specific knowledge of various cultures, whereas literature suggest that this will reinforce stereotyping. The finding that these doctors found it difficult to identify differences in their own communication behaviour could indicate that they are unaware of the specific challenges of intercultural communication and their communication behaviour in these consultations. This reflective practice study could have created the first steps of awareness regarding the communication behaviour of the doctors. A combination of experiential learning and intercultural training, is needed to create more awareness by doctors regarding their own communication behaviour. An example could be a module with reflective practice.

Chapter 7 is a study based on interviews with non-native patients. The aim of this interview study was to explore what non-native patients preferred regarding the intercultural communication with their Dutch doctor and how they experienced the communication with their doctor. Thirty non-native patients were interviewed shortly after they visited a native doctor. Interviews were in Dutch and translated by an informal interpreter when necessary. We found that the doctor's ethnic background was not important, while a professional attitude was. The results showed that the patients wanted the doctor to focus on them as a person rather than only on their disease. The patients mainly experienced the communication with their Dutch doctor as positive, but language was mentioned as a major problem in an intercultural conversation. The patients stated that a close relationship made language problems less prominent. The discussion encloses the reflection on the overlap between patient-centred communication and intercultural communication. It was concluded that generic communication of doctors was considered more important than specific intercultural communication, which could indicate the overlap between intercultural communication and patient-centred communication.

Chapter 8 summarises and discusses how the previous chapters have answered the four research questions, and which conclusions and implications this yields for intercultural communication in medical practice and education. The main findings give

insights into the complex interplay of communication in an intercultural context between doctors, patients, their companions and other components of the healthcare organisation in the Netherlands. The chapter distinguishes a practical and a critical discussion about the possible overlap between patient-centred communication and intercultural communication. The answers to the research questions were as follows: 1) Intercultural communication is an underrepresented topic in the curriculum documents of medical education; 2) Intercultural communication can be challenging due to differences in language, cultural and social differences, and doctors' assumptions. Generic communication skills, such as active listening and explaining, seems to be important in intercultural communication; 3) Doctors practice many relevant generic communication skills. However, they did not practice some specific intercultural communication skills; 4) Both patients and doctors mentioned the importance to practice generic communication skills. A language barrier was experienced as main barrier in intercultural communication.

Concluding, it remains of paramount importance to treat each patient as an unique person, irrespective of his or her cultural background, which underscores the importance of integrating intercultural communication in a patient-centred approach. In an increasingly multi-cultural and multi-ethnic world, good and effective intercultural doctor-patient communication is an indispensable professional competence that needs to be acquired and developed professionally, and this process needs to be supported by structured and dedicated training programmes.

Samenvatting

Het centrale thema van dit proefschrift is interculturele communicatie tussen artsen en patiënten. In hoofdstuk 1 wordt dit onderwerp geïntroduceerd, het probleem gepresenteerd, de achtergrond bediscussieerd, alsmede het doel en de onderzoeksvragen besproken.

Vanwege toegenomen mobiliteit, migratie en internationale samenwerking is interculturele communicatie van significant belang geworden voor de gezondheidszorg. Verschil in culturele achtergrond impliceert verschil in gewoontes, waarden, verwachtingen en percepties. Dit speelt een eminente rol in arts-patiëntgesprekken. Het begrip cultuur in sociaalwetenschappelijke zin is ruim, het omvat alle menselijke activiteiten en betekenisgeving. Cultuur is het complexe geheel van kennis, geloof, kunst, moraal, wetten, gewoontes, van alles wat een mens verwerft als lid van een gemeenschap. Cultuur omvat hoe we de wereld interpreteren en hoe we waarde en betekenis aan de ons omringende wereld kunnen toekennen. Alleen kennis van culturen is niet genoeg voor effectieve interculturele communicatie. Voor effectieve interculturele communicatie zijn ook specifieke communicatievaardigheden, gedragingen en houdingen nodig.

Het huidige medisch onderwijs is gebaseerd op training van competenties. Communicatie wordt weliswaar gezien als een van de basiscompetenties van een goede arts, maar communicatietraining zelf is vaak gelimiteerd in tijd, niet geïntegreerd in het curriculum en nauwelijks ingebed in realistische situaties uit de artsenpraktijk. De noodzaak van interculturele communicatie in de curricula van medisch onderwijs wordt in vele Westerse landen erkend, maar er is geen consensus over de meest effectieve methode om interculturele communicatie te trainen en een balans te creeren tussen houding, kennis en vaardigheden.

Het doel van dit proefschrift is om interculturele medische communicatie te onderzoeken. Hiervoor zijn de volgende onderzoeksvragen geformuleerd: 1) Wat voor soort culturele diversiteitstraining wordt aangeboden in de opleidingsplannen van de basis- en de vervolgopleidingen van de medische curricula?; 2) Wat zijn belangrijke factoren in de communicatie met niet-Nederlandse patiënten en welke vaardigheden zouden artsen kunnen toepassen voor effectieve interculturele communicatie?; 3) Welke interculturele communicatievaardigheden gebruiken artsen in de dagelijkse praktijk?; 4) Wat voor beeld hebben artsen en patiënten van de interculturele communicatie in de klinische setting en hoe beïnvloedt hun perceptie hun eigen communicatie?

Voor een overkoepelend theoretisch perspectief van dit proefschrift is een constructivistische, socio-culturele lens gekozen. Elk hoofdstuk bekijkt de interculturele communicatie vanuit een ander perspectief: de literatuur, de onderzoekers, artsen en patiënten. Het doel is om de toepasbaarheid van interculturele communicatie te begrijpen en uiteindelijk om een trainingsmethodiek te ontwikkelen voor medisch onderwijs. De hoofdstukken vormen een stapsgewijze analyse van interculturele communicatie tussen artsen en patiënten.

In hoofdstuk 2 wordt een documentanalyse uitgevoerd als startpunt in dit proefschrift. Het geeft een impressie van de mate waarin culturele diversiteit als onderwerp in opleidingsplannen van het medisch onderwijs van een multi-etnisch land is beschreven. Een uitkomst van deze analyse is dat de helft van de nationale opleidingsplannen van basisopleidingen en vervolgopleidingen verwijzingen bevat naar culturele diversiteitstraining. Aspecten van culturele diversiteit kwamen meer voor in de opleidingsplannen voor de medische basisopleidingen dan in die van de medische vervolgopleidingen. Het raamplan van de medische basisopleiding bevatte de meest uitgebreide beschrijving van aandachtspunten van culturele diversiteit. In de opleidingsplannen van de medische vervolgopleidingen was hooguit oppervlakkig en sporadisch aandacht voor dit onderwerp en de aandacht voor het onderwerp varieerde per specialisme. Het is opvallend dat een systematische beschrijving van een training in interculturele communicatie expliciet met doel, methode en evaluatie wordt gemist, omdat dit belangrijk wordt gevonden voor curriculumopbouw en ontwikkeling. We concluderen in deze documentanalyse dat, ondanks de publieke erkenning voor het onderwerp, adequate aandacht voor culturele diversiteit in de medische opleidingen van een multi-etnisch land als Nederland nog onvoldoende is. De resultaten van deze studie kunnen bijdragen aan een bewustwording van curriculumontwikkelaars en kunnen aanleiding geven om een cultureel competent curriculum te ontwikkelen.

Hoofdstuk 3 en 4 zijn gebaseerd op de ‘realist review’ methode. In hoofdstuk 3 hebben we een ‘realist review’ beschreven waarin we hebben onderzocht hoe interculturele communicatie werkt. Hoofdstuk 4 is een artikel waarin we onze ervaringen van de ‘realist’ review methode bespreken, een ‘eye opener’ studie. In een realist review worden onderzoeken samengevat volgens de ‘realist’ filosofie. De definitie van realisme is dat de onderzoeker uitgaat van een zeer complexe werkelijkheid die

te benaderen is met behulp van uiteenlopende onderzoeksmethoden. Via een 'realist review' kan men begrip voor complexe onderwerpen verbeteren. Het doel van een realist review is om de volgende vragen te beantwoorden: Wat werkt, voor wie, in welke omstandigheden en waarom?
In hoofdstuk 3 hebben we een 'realist review' uitgevoerd om de huidige kennis van de factoren die interculturele communicatie beïnvloeden samen te vatten. Daarnaast wilden we de mechanismen onderzoeken die ten grondslag liggen aan de beïnvloedende factoren van interculturele communicatie. De 'realist review' methode maakte het mogelijk om met een brede blik artikelen te includeren om de context, de mechanismen en de uitkomsten van deze artikelen te onderzoeken. In totaal werden 145 artikelen geïncludeerd. Uit deze artikelen hebben we vier communicatie-uitdagingen (contextfactoren), verschillende doelen en verschillende communicatievaardigheden (mechanismen) geëxtraheerd. Daarnaast hebben we de uitkomsten gedefinieerd als barrières of faciliterende factoren voor de interculturele communicatie. De beschreven interculturele communicatievaardigheden zijn geïnterpreteerd als generieke en specifieke vaardigheden. Met de resultaten van de 'realist review' is een raamwerk ontwikkeld dat beschrijft welke vaardigheden artsen zouden moeten toepassen om te kunnen omgaan met de uitdagingen van interculturele communicatie. Het raamwerk is gebruikt als theoretisch kader voor de daaropvolgende onderzoeken van dit proefschrift.

In hoofdstuk 5 worden de interculturele communicatievaardigheden op de polikliniek in de praktijk onderzocht. In deze observatiestudie hebben we ons gefocust op de relevante interculturele communicatievaardigheden van medisch specialisten in de dagelijkse praktijk. We hebben 39 video-opnames van arts-patiëntconsulten geanalyseerd met de gevalideerde MAAS-Globaal schaal in combinatie met het raamwerk uit de review van hoofdstuk 3: de beïnvloedende factoren van interculturele communicatie. Deze observatiestudie laat zien dat medisch specialisten vaardig zijn in het toepassen van vele communicatievaardigheden, zoals luisteren, empathisch gedrag, een open houding hebben en respect tonen naar de patiënt. Communicatievaardigheden die relevant zijn in een interculturele context, zoals cultureel bewustzijn, controleren van de taalvaardigheid van de patiënt, controleren of de patiënt het heeft begrepen en het exploreren van de reden van komst, werden niet toegepast. De communicatiestijl van de artsen was meestal biomedisch. We hebben geconcludeerd dat artsen enkele maar niet alle relevante interculturele vaardigheden in de

praktijk toepassen. Daarnaast is opgevallen dat interculturele communicatie overlap vertoont met patiëntgerichte communicatie. Een implicatie voor de praktijk zou kunnen zijn om de relevante interculturele communicatievaardigheden toe te voegen aan de bestaande patiëntgerichte communicatietrainingen.

In hoofdstuk 6 wordt een interview studie op basis van reflecteren op communicatie in de praktijk beschreven. Het doel van deze studie was om te exploreren hoe medisch specialisten interculturele communicatie ervaren, hoe ze menen interculturele communicatie toe te passen en wat ze benoemen als uitdagingen in interculturele communicatie. Zeventien semigestructureerde interviews werden gehouden met medisch specialisten van de afdelingen gynaecologie, urologie, interne geneeskunde en orthopaedie. Deze interviews werden voorafgegaan door het bekijken van fragmenten van op video opgenomen consulten van de medisch specialist. Elke medische specialist kreeg twee fragmenten te zien waarvan er één met een Nederlandse patiënt en één met een niet-Nederlandse patiënt. De opgenomen consulten werden gebruikt als voorbeeld om met de medisch specialisten te kunnen reflecteren op hun communicatie. De medisch specialisten vonden het waardevol om hun eigen consulten terug te zien. De meest opmerkelijke bevinding was dat de medisch specialisten ervoeren dat er weinig verschil was in hun communicatie met Nederlandse en met niet-Nederlandse patiënten. Ze reflecteerden vooral op hun generieke communicatievaardigheden en veel minder op interculturele communicatievaardigheden. De enthousiaste houding van de medisch specialisten ten aanzien van communicatie met niet-Nederlandse patiënten was opvallend. Ze zagen het vooral als uitdaging en niet als probleem. De medisch specialisten beschreven de volgende uitdagingen in de interculturele communicatie: taalbarrières, cultuurverschillen, de aanwezigheid van een tolk, de rol van de familie en de sfeer van het consult. Medisch specialisten gaven aan dat ze er een voorkeur voor hadden om enige specifieke kennis te hebben van de verschillende culturen. Daartegenover staat, dat de literatuur juist aangeeft dat dit niet wenselijk is omdat dit mogelijk stereotypering benadrukt. Dat deze medisch specialisten het moeilijk vonden om verschillen in hun eigen communicatie te benoemen, kan aangeven dat ze zich niet bewust zijn van de uitdagingen van interculturele communicatie en hun eigen communicatiegedrag in deze consulten. Deze studie, gebaseerd op reflecties op eigen gedrag, lijkt duidelijke stappen in de eerste bewustwording van de eigen communicatie te markeren. Een training in interculturele vaardigheden waarbij artsen vanuit eigen ervaringen kunnen werken is nodig

om meer bewustwording bij artsen te creëren rondom hun communicatiegedrag en -vaardigheden. Een dergelijke trainingsmodule kan bestaan uit het reflecteren op eigen communicatie op basis van video-observaties.

Hoofdstuk 7 is een interviewonderzoek met niet-Nederlandse patiënten. Het doel van dit onderzoek was om de voorkeuren van niet-Nederlandse patiënten rondom interculturele communicatie met Nederlandse artsen te exploreren. Daarnaast werd gevraagd hoe de niet-Nederlandse patiënten de interculturele communicatie met hun arts ervoeren. Dertig niet-Nederlandse patiënten werden geïnterviewd na hun bezoek aan de Nederlandse arts. De interviews werden in het Nederlands gehouden en indien nodig vertaald door een informele tolk. We vonden dat de etnische achtergrond van de arts niet van belang was voor deze niet-Nederlandse patiëntengroep. Belangrijker was de professionele houding van de arts. De patiënten hadden de voorkeur voor een persoonsgerichte arts in plaats van een arts die zich vooral richtte op de ziekte. De meeste patiënten hadden vooral positieve ervaringen met Nederlandse artsen, al werd een taalbarrière genoemd als groot probleem in de communicatie. De patiënten benoemden dat een goede arts-patiëntrelatie ervoor zorgde dat de taalbarrière een minder prominent probleem werd. De discussie van het onderzoek gaat over de overlap tussen patiëntgerichte en interculturele communicatie. Een uitkomst uit dit deel van het onderzoek is dat de niet-Nederlandse patiënten in dit onderzoek de generieke communicatievaardigheden van artsen belangrijker vonden dan de specifieke interculturele communicatievaardigheden. Dit geeft de grote overlap aan tussen interculturele en patiëntgerichte communicatie.

Hoofdstuk 8 vat alle hoofdstukken samen en bediscussieert hoe de onderzoeken de onderzoekvragen hebben beantwoord. Daarnaast worden conclusies getrokken en aanbevelingen voor de medische praktijk en het medisch onderwijs gedaan. De belangrijkste bevindingen laten zien dat er een complexe wisselwerking is tussen artsen, patiënten, hun familie en andere componenten van de gezondheidszorg in Nederland. Hoofdstuk 8 geeft tevens een kritische en praktische discussie over de overlap van patiëntgerichte communicatie en interculturele communicatie weer. De antwoorden op de onderzoeksvragen zijn als volgt: 1) Interculturele communicatie is een weinig belicht onderwerp in de opleidingsplannen van het medisch onderwijs; 2) Interculturele communicatie stelt uitdagingen op het gebied van taalbarrières, culturele en sociale verschillen en de aannames van artsen. Generieke communicatievaar-

digheden, zoals actief luisteren en uitleggen, lijken van belang in interculturele communicatie; 3) Artsen passen vele relevante generieke communicatievaardigheden toe, maar passen minder vaak de relevante specifieke interculturele vaardigheden toe; 4) Zowel artsen als patiënten benoemden het belang van het toepassen van generieke communicatievaardigheden door de arts. Een aanwezige taalbarrière werd ervaren als de grootste barrière in interculturele communicatie.

Er wordt geconcludeerd dat in multiculturele landen, effectieve, patiëntgerichte interculturele communicatie onmisbaar is. De overlap van interculturele communicatie en patiëntgerichte communicatie verdient daarom meer aandacht in het medisch onderwijs, waar gestructureerde en toegewijde trainingsprogramma's kunnen bijdragen aan verbetering van de arts-patiënt communicatie.

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About the author

Emma Paternotte was born on April 9th 1986 in Amsterdam, the Netherlands. From 2004 to 2010 she studied Medicine at the Medical Faculty of the Vrije Universiteit in Amsterdam.

In February 2011 she started working as a resident (not in training) in obstetrics and gynaecology at OLVG west (formerly known as the Sint Lucas Andreas hospital) in Amsterdam. In addition to her work as doctor she started research activities in the field of intercultural communication. In March 2012 the focus of her activities shifted to scientific research which she combined with a position as coordinator of medical education. Initially her work focussed on coordination of undergraduate medical education and later postgraduate medical education was added. She supports various specialties of postgraduate medical education in the merger of the OLVG hospitals.
At the end of this year she will start her residency in obstetrics and gynaecology at the University Medical Centre of Utrecht (A Frankx M.D.PhD.Prof). She will be able to practice what she loves and proof to be a patient-centred, compassionate doctor with special attention for education and research.
Her main research interests are cultural diversity and communication between doctors and patients, training of this topic in medical education, and qualitative research.
Her main personal interests are race biking, climbing and music.

She lives together with Giel van Stralen in Utrecht and they are expecting their first child in September 2016.

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