Cultural differences in medical communication: A review of the literature

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Abstract

Objective: Culture and ethnicity have often been cited as barriers in establishing an effective and satisfying doctor–patient relationship. The aim of this paper is to gain more insight in intercultural medical communication difficulties by reviewing observational studies on intercultural doctor–patient communication. In addition, a research model for studying this topic in future research is proposed.

Methods: A literature review using online databases (Pubmed, Psychlit) was performed.

Results: Findings reveal major differences in doctor–patient communication as a consequence of patients’ ethnic backgrounds. Doctors behave less affectively when interacting with ethnic minority patients compared to White patients. Ethnic minority patients themselves are also less verbally expressive; they seem to be less assertive and affective during the medical encounter than White patients.

Conclusion: Most reviewed studies did not relate communication behaviour to possible antecedent culture-related variables, nor did they assess the effect of cultural variations in doctor–patient communication on outcomes, leaving us in the dark about reasons for and consequences of differences in intercultural medical communication. Five key predictors of culture-related communication problems are identified in the literature: (1) cultural differences in explanatory models of health and illness; (2) differences in cultural values; (3) cultural differences in patients’ preferences for doctor–patient relationships; (4) racism/perceptual biases; (5) linguistic barriers. It is concluded that by incorporating these variables into a research model future research on this topic can be enhanced, both from a theoretical and a methodological perspective.

Practice implications: Using a cultural sensitive approach in medical communication is recommended.

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Keywords: Intercultural communication; Doctor–patient communication; Medical communication; Ethnicity; Review
1. Introduction

A recent issue in the study of doctor–patient interaction is the relation between patients' ethnic background and medical communication, and the fundamental question this raises to what extent belonging to an ethnic/cultural group influences the communication process between patients and health care practitioners. To pose this question is of vital importance, because in today's multicultural society health care practitioners are increasingly confronted with patients from different cultural and ethnic backgrounds. For instance, in The Netherlands more than 18% of the population is from other ethnic origin nowadays [1]. Encounters with these patients are likely to differ from meetings between doctors and patients sharing the same cultural or ethnic background, because people from different cultures hold different beliefs about health, illness and communication [2,3]. These divergent beliefs, as well as linguistic barriers that often exist between members of different cultures, confront health care practitioners with the difficult task to deliver good quality care to a wide diversity of patients, each bringing his own unique background to the medical encounter.

Culture1 and ethnicity have often been cited as barriers in establishing an effective and satisfying doctor–patient relationship [4–6]. For example, results of a number of survey studies indicate that there is more misunderstanding, less compliance and less satisfaction in intercultural medical consultations compared to intra-cultural medical consultations,2 even after adjusting for socio-economic variables such as education and income [7–10]. Moreover, health care providers find consultations with ethnic minority patients often emotionally demanding and patients' reasons for visiting unclear [11,12]. Furthermore, numerous studies have shown that there are considerable disparities in access to care as well as in health outcomes as a consequence of patients’ ethnic background. For example, ethnic minority patients are less likely to be recommended for certain treatments than White patients [13,14]. Although these disparities in health (care) are probably partly related to socio-economic variables such as income, gaps in doctor–patient communication are likely to play a crucial role as well, since it is well known that this factor is positively associated with various health-related outcomes [15]. Hence, possible gaps in intercultural medical communication seem to place ethnic minority patients at an increased risk of receiving inferior care.

The overall aim of the present study is to gain more insight into the effects of patients’ and doctors’ cultural/ethnic backgrounds on the medical communication process. Main research question is whether there are any differences in doctors’ and patients’ communicative behaviour between intercultural and intra-cultural consultations, and if so, which differences. A second question concerns how these differences may be explained and what consequences they have for patient outcomes, such as patient satisfaction, compliance and understanding. Because our focus in this review is on communicative behaviour, we will investigate the first research question by reviewing observational studies on intercultural medical communication as this method yields the most reliable data with regard to assessing behaviour. However, with respect to the second research question, the broader literature on intercultural health communication (including other research methods as surveys, focus groups and so on) will be included as this may add relevant findings to the results of our observational review. Combined with our review results, in the second part of this article these findings will be used to design a research model that can be used in future research on this topic.

2. Methods

We performed a literature review using online databases (Pubmed, Psychlit), and searched for further eligible literature through references in scientific papers and books. The following key words were used, in different combinations: doctor–patient communication, physician–patient communication, culture, ethnicity, race, diversity, non-English
speaking, intercultural communication, cross-cultural communication, medicine, language barriers, medical consultation, medical communication and medical interview. Publications were included if they met the following criteria:

1. The study was directed at the verbal and/or non-verbal communication between doctors and patients, with patients and doctors having dissimilar cultural/ethnic backgrounds.
2. The study involved either audio or video recordings of the consultation or direct scoring of doctor–patient communication during consultations.
3. The study was published in English from 1974 to 2004.

The literature search produced 14 articles meeting the inclusion criteria. These articles examined the impact of patients’ culture/ethnicity on doctor–patient communication and formed the basis of the current review study. The studies were evaluated in terms of their methods, research questions and findings, and whether variations in doctor–patient communication were related to antecedent factors and outcome measures.

3. Results

3.1. Study design and methods

Table 1 contains an overview of the study design and methods used; 12 studies were quantitative and two studies qualitative in nature. Most studies were carried out in the United States during the last decade within the setting of a family practice or general practice. Participating physicians were mostly residents in their second or third year of medical training (in the US) or general practitioners.

Patients’ age and sex was reported in the quantitative studies and mostly their educational level too, whereas patients’ language proficiency was only reported twice [19,25]. The reason of visit, patients’ perceived health, the extent to which doctor and patient knew each other and patients’ religious background were infrequently mentioned. Age and sex of the physician were reported in most quantitative studies.

The studies most frequently involved a comparison of doctor–patient communication between visits of patients belonging to one of the major ethnic minority groups, White physicians on the one hand, and visits of White patients to White doctors on the other. In the American studies ethnic minority patients were African, Americans and Hispanics; in the Dutch studies they were mainly of Surinamese, Antillean, Turkish or Moroccan background, and in the Australian study they were Aborignals.

Except for the study by Cooper et al. [28], none of the studies explicitly reported matching patients’ and physicians’ ethnicity. The sample size of the qualitative studies ranged from five to nine, and for the quantitative studies from 51 to 458. With regard to the observational strategy, eight studies were based on audiotapes, four on videotapes, and two study directly assessed doctor–patient communication. Four studies applied the Roter Interaction Analysis System (RIAS) [30] to code the verbal behaviour of participants. This category system distinguishes between instrumental utterances, such as information-giving and question-asking, and affective utterances, such as showing empathy and giving reassurance. Henbest and Stewart’s patient-centeredness measure was used in the study by Rivadeneyra et al. [20]. This system assesses the extent to which a physician responds to patients’ offers, that is, ‘any topic or question introduced by the patient during the medical encounter that was not a direct answer to a physician’s question’ [20]. The other six quantitative studies made use of self-developed analysis systems; all of these were category systems coding (frequencies of) various aspects of participants’ verbal behaviour. Just one study assessed non-verbal behaviour [17]. Erzinger [18] made use of conversation-analytical micro-analysis, Cass et al. [22] did not mention their observational instrument.

Nine of the quantitative studies mentioned inter-rater reliabilities, which in general were satisfactory (except for one study). Finally, about half of the studies mentioned sampling method and response rates.

3.2. Research questions and findings

The aim of all the studies was to assess the effect of patients’ ethnic background on the medical communication process (Table 2). To realise this objective, most studies compared the communication process between White doctors and White patients with the communication process between White doctors and ethnic minority patients. Both doctors’ and patients’ communicative behaviour was investigated, and in most cases encounter length was assessed too. We will first discuss findings related to doctors’ communicative behaviour, then turn to findings on patients’ communicative behaviour. Finally, we will present results on possible factors related to differences in and consequences of (gaps in) intercultural communication.

3.2.1. Doctors’ communicative behaviour

In general, all studies found significant differences in doctors’ behaviour when comparing consultations with White patients and ethnic minority patients. These differences concerned doctors’ affective and instrumental verbal behaviour as well as consultation length. Most studies found that physicians showed less affective behaviour when communicating with ethnic minority patients [16,17,23,24,28,29], but other results indicated no differences or, on the contrary, found that doctors were more affective towards ethnic minorities [25]. Three studies [16,17,28] showed significantly decreased empathy with
Table 1
Overview of studies on intercultural doctor–patient communication: setting, sample and method

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Practice</th>
<th>Patient sample</th>
<th>Doctor sample</th>
<th>Observational strategy</th>
<th>Observational instrument</th>
<th>Inter-rater reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shapiro and Saltzer [16]</td>
<td>USA</td>
<td>Resident clinic</td>
<td>39 WA, 15 LES-Hispanics, 7 ES-Hispanics (n = 61)</td>
<td>10 WA family practice resident physicians (n = 10)</td>
<td>Audiotapes</td>
<td>Self-developed interaction analysis instrument</td>
<td>Range: 0.50–0.61 (correlation)</td>
</tr>
<tr>
<td>Hooper et al. [17]</td>
<td>USA</td>
<td>Outpatient clinic of teaching hospital</td>
<td>67 WA, 74 Hispanics (n = 150)</td>
<td>15 WA resident physicians (n = 15)</td>
<td>Direct ratings of interaction through one-way mirror</td>
<td>Self-developed interaction analysis instrument</td>
<td>94% agreement</td>
</tr>
<tr>
<td>Erzinger [18]</td>
<td>USA</td>
<td>Family practice residency at public hospital</td>
<td>9 Hispanics (n = 9)</td>
<td>Not reported</td>
<td>Audiotapes, transcripts</td>
<td>Conversation analysis</td>
<td>NRb</td>
</tr>
<tr>
<td>Seijo et al. [19]</td>
<td>USA</td>
<td>Internal medicine clinic</td>
<td>51 Hispanics (n = 51)</td>
<td>5 WA internal medicine physicians, 4 Latin American physicians</td>
<td>Direct ratings of interaction</td>
<td>Self-developed interaction analysis instrument</td>
<td>NR</td>
</tr>
<tr>
<td>Rivadeneira et al. [20]</td>
<td>USA</td>
<td>Primary care clinic affiliated with university</td>
<td>15 WA, 19 LES-Latinos, 4 ES-Latinos (n = 38)</td>
<td>3 WA, 4 Asian, 1 Middle Eastern primary care (resident) physicians (n = 8)</td>
<td>Videotapes</td>
<td>Henbest &amp; Stewart’s Patient-Centeredness Measure</td>
<td>0.96 (correlation)</td>
</tr>
<tr>
<td>Sleath et al. [21]</td>
<td>USA</td>
<td>Family practices and general internal medicine clinics at university</td>
<td>153 WA, 254 Hispanics (n = 407)</td>
<td>19 WA, 6 Hispanic, 2 Asian family practice or general internal medicine resident physicians (n = 27)</td>
<td>Audiotapes, transcripts</td>
<td>Self-developed interaction analysis instrument</td>
<td>Range: 0.80–0.93 (Cronbach’s alpha)</td>
</tr>
<tr>
<td>Cass et al. [22]</td>
<td>Australia</td>
<td>Satellite dialysis unit</td>
<td>5 Aboriginal (n = 5)</td>
<td>5 White Australian physicians (n = 5)</td>
<td>Videotapes</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>van Wieringen et al. [23]</td>
<td>The Netherlands</td>
<td>General practices</td>
<td>48 Ethnic minority (mostly Surinamese/Turkish/Moroccan), 38 Dutch (n = 87)</td>
<td>7 Dutch, 1 Aruban general practitioners (n = 8)</td>
<td>Videotapes</td>
<td>Roter interaction analysis system</td>
<td>NR</td>
</tr>
<tr>
<td>Sleath and Rubin [24]</td>
<td>USA</td>
<td>Family practices and general internal medicine clinics at university</td>
<td>141 WA, 242 Hispanic (n = 383)</td>
<td>19 WA, 6 Hispanic, 2 Asian family practice or general internal medicine resident physicians (n = 27)</td>
<td>Audiotapes, transcripts</td>
<td>Self-developed interaction analysis instrument</td>
<td>Range: 0.61–0.87 (correlation)</td>
</tr>
<tr>
<td>Harmsen [25]</td>
<td>Netherlands</td>
<td>Family practices</td>
<td>34 Ethnic minority (mostly Surinamese/Turkish/Moroccan), 32 Dutch (n = 66); children</td>
<td>7 Dutch general practitioners (n = 7)</td>
<td>Videotapes</td>
<td>Roter Interaction Analysis System</td>
<td>Range: 0.55–0.79 (correlation)</td>
</tr>
</tbody>
</table>
ethnic minority patients compared to White patients. Harmsen [25] found that doctors expressed more empathy with ethnic minority patients during pediatric consultations, and Sleath et al. [21] could not detect significant differences in physicians’ expressions of empathy when comparing Hispanic with White American patients. Other affective behavioural variables assessed in the studies were the extent of rapport-building [16], physicians’ responsiveness towards patients’ offers [20], physicians’ expressiveness of positiveness [21], and affective verbal behaviour as categorised by RIAS, such as physicians’ social talk and partnership-building [23,28,29]. All studies reported significantly lower scores on these variables in consultations with ethnic minority patients compared to White patients: there was less social talk and rapport-building, doctors were rated as less friendly and concerned, and patients’ comments were ignored by their doctors more often.

With regard to instrumental verbal behaviour, physicians were rated higher on giving medical explanations [16] and on interviewing skills (using open-ended questions and allowing patients to ask questions) when communicating with Anglo-American patients compared to Hispanic patients [17]. Sleath et al. [26] found that doctors communicated more about antidepressants use with White patients than with Hispanics. At the same time, they asked more questions about anxiety in consultations with Hispanics than with White patients [24]. Four studies reported no significant differences with regard to doctors’ instrumental verbal behaviour [20,23,25,28].

Results on consultation length were inconsistent. Johnson et al. [29] and Hooper et al. [17] did not find any difference in consultation length between visits of Anglo-American and Spanish-American patients, while Harmsen [25] reported that consultations with ethnic minority patients were on average 3 min longer than consultations with White patients. In contrast, Cooper et al. [28] found that race-concordant visits were significantly longer than race-discordant visits (about 2 min), and also had lower speech speed.

Erzinger [18] identified various ‘communicative tasks’ for both doctors and patients, which should be completed for a medical encounter to be successful. Communication styles were either described as supportive or conflictual, depending on whether participants assisted each other in completing the communicative tasks. Both communication styles occurred in these medical encounters, suggesting that some consultations with ethnic minority patients were going smoothly while others were not. Cass et al. [22] found that a shared understanding between doctors and Aboriginal patients was rarely achieved. Patients had few opportunities to initiate a topic; the doctor determined the conversational direction and often patients acted politely, which health care practitioners were seldom aware of.
<table>
<thead>
<tr>
<th>Study</th>
<th>Research questions</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Effect of doctor–patient communication on patient understanding and compliance</td>
<td>Relationship between language and ethnicity &amp; patient understanding.</td>
</tr>
<tr>
<td>Hooper et al. [17]</td>
<td>Effect of patient characteristics on physicians’ information conveyance, interviewing skills, empathy, nonverbal attention, courtesy and consultation length</td>
<td>No differences between ethnic groups on compliance.</td>
</tr>
<tr>
<td>Erzinger [18]</td>
<td>Exploration of communication problems of Spanish-speaking patients in the USA</td>
<td>Better interviewing skills and more empathy with Anglo-American than with Spanish-American patients.</td>
</tr>
<tr>
<td>Seijo et al. [19]</td>
<td>Comparison of doctor–patient communication (i.e., patients' question-asking and doctors' information-giving) between language-concordant and language discordant visits</td>
<td>No difference between language-concordant and language-discordant consultations on amount of doctors' information-giving behaviour.</td>
</tr>
<tr>
<td></td>
<td>Differences in patient recall between language-concordant and language discordant visits</td>
<td>More patient question-asking in language-concordant than in language-discordant consultations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>English-speaking patients received more responses than Spanish-speaking patients.</td>
</tr>
<tr>
<td>Sleath et al. [21]</td>
<td>Comparison of physicians’ expression of empathy and positiveness between Hispanic and White patients</td>
<td>No difference in frequency of physicians’ responses between English-speaking Latino patients and White English-speaking patients.</td>
</tr>
<tr>
<td>Cass et al. [22]</td>
<td>Exploration of the extent of miscommunication between Australian doctors and Aboriginal patients</td>
<td>More expression of positiveness to White patients than to Hispanic patients.</td>
</tr>
<tr>
<td>van Wieringen et al. [23]</td>
<td>Effect of communication and patient beliefs on understanding and compliance of White and ethnic minority patients</td>
<td>Differences in patient beliefs between ethnic minority patients and White patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultations with ethnic minority patients show less social talk, less doctors' concern and less doctors’ friendliness than consultations with White patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physicians were more likely to ask Hispanic patients questions about anxiety than White patients.</td>
</tr>
<tr>
<td></td>
<td>Effect of education and language proficiency on doctor–patient communication</td>
<td>Ethnic minority patients expressed less interest and concern than White patients.</td>
</tr>
<tr>
<td></td>
<td>Differences in consultation length and prescription behaviour</td>
<td>Education and language proficiency unrelated to communication differences.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultation length is longer with ethnic minority patients.</td>
</tr>
</tbody>
</table>
3.2.2. Patients’ communicative behaviour

A majority of the quantitative studies investigated differences in patients’ verbal behaviour as a function of ethnic background. Findings of these studies indicated that ethnic minority patients express less affective and instrumental verbal behaviour than White patients and that they seem to be less assertive. For instance, in the Dutch studies it was found that ethnic minority patients expressed less concern as well as less friendliness and social talk [23,25]. These findings are supported by the results of the American studies, which also yielded evidence of less expression of verbal behaviour by ethnic minority patients [29]. Sleath et al. [26,27] found that White Americans were almost twice more likely to complain and to state information about their antidepressants than Hispanics. In another study, significantly higher ratings of positive patient affect (i.e. friendliness, interest, responsiveness and engagement) were found in race-concordant as opposed to race-discordant visits [28]. Rivadeneyra et al. [20] found that Spanish-speaking patients mentioned fewer symptoms, feelings, expectations and thoughts than English-speaking patients. It should be noted however that no differences emerged between Latino and non-Latino English-speaking patients, indicating that differences might be attributable to language rather than to ethnicity. More evidence for the role of language on patients’ communicative behaviour comes from a study by Seijo et al. [19], in which significant differences were found on the amount of patients’ question-asking between language-concordant and language-discordant consultations. Patients who communicated in their own language with their physician (i.e. Spanish) asked more questions than Hispanic patients who had to speak English.

3.2.3. Culture’s influence on doctor–patient communication: antecedents and outcomes

The variable most often studied (seven times) as a culture-related explanatory factor of gaps in intercultural medical communication has to do with linguistic factors. Most studies did not find any relation between linguistic factors and variations in communication though. Results of
the study by Rivadeneyra et al. and Seijo et al. [19,20] show that language may have had an impact on physicians’ communicative behaviour. Also, Cass et al. [22] suggest that employing differing modes of discourse leads to intercultural communication problems. Other predictor variables were seldom incorporated in the studies, although Cass et al. [22] suggest that differences in beliefs about health and illness as well as differences in cultural values between members of different ethnic groups are associated with gaps in doctor–patient communication. As far as educational level is concerned, results are mixed. Harmsen [25] could not establish a significant relation between education and communication, whereas Sleath et al. [24,26,27] found that higher educated ethnic minority patients did communicate more about depression issues and also received more positive responses from their doctors than lower educated ethnic minority patients.

Three studies assessed the impact of intercultural doctor–patient communication on a number of health-related outcomes, such as patient understanding, compliance and satisfaction [23,26,28]. All in all, no relationship could be demonstrated between the communication process and these outcome variables. Difficulties in communicating with ethnic minority patients did not result in worse compliance, satisfaction and understanding as compared to communicating with White patients. What was found is that ethnic minority patients were less satisfied with GPs’ communicative behaviour and were less compliant, and that less mutual understanding was achieved between ethnic minority patients and their GPs [16,23,26,28]. Harmsen [25] found that ethnic minority patients were prescribed medication more often than White patients, irrespective of differences in communication. It therefore seems that patients’ ethnicity has an independent and negative effect on outcomes, regardless of the communication process as measured by the observational instruments used in these studies.

4. Discussion and conclusion

In reviewing the literature on intercultural medical communication we only found a handful of observational studies addressing this topic, yielding partly inconsistent results. To some extent, these contradictory findings may have emerged as a consequence of the wide variety of research questions and designs used in the studies. This makes it hard to reach definite conclusions about the cultural variability of doctor–patient communication. Besides, none of the studies under review explained on what definition the categorization criteria and the reporting of results per ethnic minority group was based. It would be worthwhile in future research to clearly state how the various patients are categorised into different ethnic groups, and to take into consideration the considerable variation that may exist between and within ethnic minority groups. For instance, in the Dutch studies Turkish and Moroccan patients are regarded as one (Muslim) group, despite the fact that there are considerable differences between the two groups on a number of factors relevant for the topic of doctor–patient communication, such as their average educational level (Turkish people in The Netherlands are higher educated and more literate than Moroccan people in The Netherlands). In short, clarification of categorization criteria and the reporting of results per ethnic minority group would greatly enhance the possibility to compare across studies and to reach more definite conclusions, which may well differ between the various ethnic minority groups.

Taking into account the above, it seems safe to conclude that findings do suggest considerable differences and difficulties in communication between doctors and patients from different cultural and ethnic backgrounds. There is evidence suggesting that doctors behave less affectively when interacting with ethnic minority patients. More or less the same can be said of doctors’ instrumental verbal behaviour, although these results were less pronounced. Ethnic minority patients themselves were also less verbally expressive and seem to be less assertive and affective during the medical encounter than White patients. These findings are mostly in concordance with results of another review study on the topic of culture and the doctor–patient relationship, which also indicated less affective and assertive behaviour in medical consultations with minority patients [31].

Although the current review clearly shows that there is considerable variation in doctor–patient communication as a consequence of patients’ ethnic background, explanations for and consequences of these communication differences were only seldom incorporated in the studies. For instance, why White doctors and ethnic minority patients express less affective verbal behaviour towards each other is hard to tell because most of the studies did not relate communication behaviour to possible predictor variables, except for patients’ ethnic background. The only other variable researched in the studies under review concerns linguistic barriers, and in general no relationship could be established between this variable and variations in doctor–patient communication [16,25]. None of the intercultural medical communication studies has incorporated any other predictor variables, leaving us in the dark about possible explanatory mechanisms beyond culture and ethnicity for gaps in intercultural doctor–patient communication.

With regard to the consequences of gaps in intercultural medical communication, studies could not demonstrate a relationship with difficulties in doctor–patient communication. Findings clearly showed that ethnic minority patients suffer worse health-related outcomes, such as satisfaction and compliance, than White patients, but patients’ ethnicity seemed to have an independent effect. This could be due to the fact that other culture-related variables not assessed in these studies influence patient satisfaction, understanding and compliance. For instance, in two studies by Brown and Segal [32,33] it was found that African-Americans were
more present-oriented than Whites in the daily management of their hypertension, which is possibly related to higher non-compliance rates and greater use of home remedies. However, as it is well established that good doctor–patient communication is associated with improved health outcomes [15], it is difficult to assume that no relationship exists between intercultural problems in medical communication and patient outcomes. This points to the necessity to make use of other observational instruments than the ones most frequently employed at present (i.e. RIAS, other self-developed frequency systems) to assess doctor–patient communication. Specifically, almost all studies under review have made use solely of frequency systems that focus on the relational aspects of communication (instrumental versus affective), thereby neglecting other, more content-related, aspects of communication. Frequency countings of behaviour however do not shed light on the dynamics of the communication process, thereby running the risk of leaving essential aspects of difficulties in intercultural medical communication undetected. In addition to the traditional quantitative measures of communication behaviour more qualitative methods of observational analyses should be employed, as we want to gain more insight into gaps in intercultural medical communication.

From a methodological perspective, it is not only necessary to use more diverse observational means and analysis systems (e.g. none of the studies systematically investigated cultural differences in non-verbal behaviour) when investigating the doctor–patient communication process, other research designs should also be employed. For instance, except for the study by Cooper et al. [28], none of the studies matched patients and doctors on their ethnic background. Hence, most studies only compared White doctor-ethnic minority patient dyads with White doctor–White patient dyads. However, Cooper et al. [28] found that race-concordant pairs of physicians and patients had higher ratings of positive affect than race-discordant pairs, suggesting that it is perhaps not patients’ ethnic background per se, but differences in ethnic and cultural background that lead to difficulties in the medical communication process. Perhaps resemblance in communication styles among members of the same ethnic groups enhances verbal expressions, while differences may get in the way of a smooth flow of conversation. To test for this possibility, future research should also incorporate other dyads, such as ethnic minority patient and ethnic minority doctor dyads, which up to now have been absent from research on this topic.

Finally, a closely related methodological issue is the need to make use of coders who are of the same ethnic background as the patients whose behaviour they score. Although none of the studies stated the ethnic background of the people who scored patients’ and doctors’ communicative behaviour, it is likely that predominantly White people were used. This may lead to bias in several ways. First, as it is nearly impossible in this kind of research to code blindly, the fact that one knows that one scores behaviour of ethnic minorities may in itself lead to bias, because the label ‘ethnic minority’ is associated with other connotations than the label ‘White’ or ‘native-born’. Second, the risk of interpreting the communicative behaviour of someone from another ethnic group incorrectly may be higher than interpreting the communicative behaviour of someone belonging to one’s own group, because of lack of knowledge about cultural differences in communication styles [34]. Consequently, future research should not only incorporate other doctor–patient dyads but also add ethnic minority coders. Thus, to be able to disentangle possible ethnic effects on doctor–patient communication, the most effective research design would be a two (White versus non-White doctor) by two (White versus non-White patient) by two (White versus non-White coder) design.

4.1. Proposal of research model

This review clearly shows that there is a profound lack of knowledge about a wide range of issues related to the complex research field of intercultural medical communication. There are hardly any empirical studies in which doctor–patient communication has been assessed directly, and most of the study findings are hard to compare because of differences in definitions, aims and research designs. Moreover, the majority of the studies did not relate communication difficulties to outcome measures, nor did they measure possible explanatory mechanisms for these communication problems. This has resulted in an atheoretical, purely descriptive research field, without a coordinating principle in which the different research parts can be brought together. Without such a guiding principle we can hardly expect to find effective solutions for the communication problems encountered within intercultural medical visits. It is thus first and foremost necessary to design a model on which future research in this area can be based. For this reason we have examined the broader literature on intercultural (medical) communication and identified five variables likely to play a significant role in explaining culture’s influence on medical communication. We will discuss these factors in more detail now and propose a research model that can be used to advance the research field of intercultural medical communication.

4.1.1. Cognitive processes: Kleinman’s explanatory model

To understand how patients’ cultural background may influence doctor–patient communication, Kleinman has proposed the idea of the Explanatory Model (EM) [3,35]. EM is defined as ‘the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process’. Both patients and doctors hold EMs as they offer explanations of episodes of sickness and appropriate treatments. According to Kleinman, there will
often be discrepancies between patients’ and doctors’ EMs, resulting in gaps in doctor–patient communication. These discrepancies result from patients’ EMs being heavily influenced by personality and cultural factors, while doctors’ EMs are mostly based on a more narrow biomedical perspective. With regard to the question of how to empirically study culture’s influence on patients’ EMs, the model proposed by Angel and Thoits [36] is particularly promising. It describes how culture impacts on certain cognitive structures that mediate people’s interpretation of physical and emotional states, such as the likelihood of certain states being labelled as symptoms, the evaluation of these symptoms and so on, and is a worthwhile starting point for more extensive research on this topic. Maclachlan [37] offers another relevant method; he designed a technique for assessing the interplay of culture and health in such a way that it acknowledges the influence of culture on health by embracing the pluralism of conceptual perspectives.

4.1.2. Cultural values: individualism–collectivism and self-construals

One of the dimensions most often used in explaining variations in communication between cultures is the individualism–collectivism construct [38,39]. In short, people belonging to predominantly individualistic cultures see the self as independent of groups, whereas in collectivistic cultures the self is seen as part of the group. Personal goals are more important in individualistic cultures, while goals and norms of the group prevail in more collectivistic-oriented societies. The distinction between individualistic and collectivistic cultures provides a useful framework for understanding cultural variations in communication, and there is indeed much research showing that rules for communication and conversation as well as actual communication behaviour differ between these two types of cultures. For example, Asians, who are collectivistically oriented, are less assertive and less direct in their conversations than Americans, who are individualistically oriented [40,41]. Moreover, collectivists pay more attention to the situation and to paralinguistic cues, whereas individualists pay more attention to the exact content of the message but tend to neglect the paralinguistic cues [39,42]. Hall [43] explained this variation in communication style by differentiating between low- and high-context communication. The kind of communication style people use and find most appropriate also differs between individuals within a single country who belong to different ethnic groups [44].

Within medicine, Young and Klingle [45] hypothesised that cultural norms influence patients’ assertiveness, their perceived ability to perform certain responses (self-efficacy) and their conviction that the recommended response is effective (response-efficacy), which together influence the amount of patient participation. Although there were no cultural differences between response- and self-efficacy, they were indeed related to patient participation (assertiveness was not), so the hypothesised explanatory mechanisms for culture’s influence on patient participation were not substantiated. In a study by Kim et al. [46], cultural differences in willingness to be assertive and beliefs about participation did emerge. They found that Asians had fewer positive beliefs about patient participation than Western participants and were less willing to be assertive. Perhaps the perceived appropriateness of assertiveness rather than the perceived ability to be assertive or the perceived effectiveness of assertiveness mediates the influence of patients’ cultural background on patient participation, as is also suggested by Young and Klingle [45].

While it is clear that the individualism–collectivism construct provides a useful framework for understanding cultural differences in communication behaviour, it does not clarify the underlying psychological processes to which these differences may be attributable. Besides, it does not take into consideration the heterogeneity in behaviour and underlying values within single cultures [47]. One of the factors that have been identified as possible mediator of the influence of cultural individualism–collectivism on communication behaviour is the individuals’ self-construal, in terms of independent versus interdependent [48]. The independent construal of the self ‘...requires construing oneself as an individual whose behaviour is organized and made meaningful primarily by reference to one’s own internal repertoire of thoughts, feelings, and action, rather than by reference to the thoughts, feelings, and actions of others’ [48, p. 226]. The interdependent construal of the self ‘...entails seeing oneself as part of an encompassing social relationship and recognizing that one’s behaviour is determined, contingent on, and, to a large extent organized by what the actor perceives to be the thoughts, feelings, and actions of others in the relationship’ [48, p. 227]. It is assumed that in collectivistic cultures individuals tend to rely more on their interdependent self, whereas people in individualistic cultures rely mainly on their independent self. It has been shown however that these two self-construals coexist in individuals, and that it is partly the situation that determines which of the two self-construals is activated [49]. Gudykunst et al. [50] demonstrated that self-construals are better predictors of and explain more variance in communication style than the individualism–collectivism construct.

4.1.3. Motivational processes: patient preferences

An indisputable shift in the doctor–patient relationship has been noticeable in the last couple of decades. Because of several societal and technological changes during that time period in the Western world [51], the traditional paternalistic way of treating patients is no longer considered acceptable; instead, a model of mutual participation in which patient education, patient involvement and shared decision-making are the new conventions and patient autonomy the new ethos is advocated [52,53]. One of the key dimensions underlying this paradigm shift is the
concept of patient-centeredness, that is, the ideal of an egalitarian doctor–patient relationship in which doctors and patients share responsibility for the interaction and its outcomes [54,55].

One of the main assumptions underlying ideas about shared decision-making and mutual participation is that patients prefer to be involved in their own care. This assumption may not be valid for every patient and in every situation though. It has been shown that depending on one’s personality (e.g., locus of control, assertiveness), beliefs about the extent to which powerful others such as doctors should be responsible for making decisions about patients’ health differ [56]. Patients’ ethnic background is also related to differences in preferences for different types of doctor–patient relationships. For instance, Korean-Americans and Mexican-Americans have less need for information disclosure and participation in decision-making than White American patients [57]. Furthermore, patients from different European countries attach different importance to various communication aspects, such as the amount of biomedical and psychosocial communication they consider important [58]. Although it is likely that some elements of patient preferences are universal, such as the need to be heard and understood, other aspects are likely to be culture-bound. For instance, for Chilean patients being touched by their doctor is an important attribute, while British patients do not mention this as a valuable quality [59]. This finding may reflect a culture-specific translation of a universal need to feel understood.

4.1.4. Perceptions: racism/bias

Another barrier to adequate doctor–patient communication in interethnic encounters is the issue of racism and perceptual bias [60,61]. For instance, American physicians perceive their Black patients as being less intelligent, more likely to perform high-risk behaviours and more likely to be non-compliant than White patients. They also have less affinity feelings towards Black patients compared to White patients [62]. When ethnic minority patients are asked about racist experiences, they are more likely to perceive racism, report mistrust and, in general, perceive more unfairness in the treatment they need than Whites [63,64].

Apart from the study by van Ryn and Burke [62], whether the racist experiences ethnic minority patients perceive correspond with how they are actually treated by physicians and the health care system in general has not been empirically studied yet. However, their perceptions are likely to have a negative impact on the quality of care and should therefore be topic of research in the field of intercultural doctor–patient communication [63,65].

4.1.5. Language: linguistic barriers

One obvious hindrance to intercultural communication is the often-encountered lack of language understanding between doctors and patients belonging to different ethnic/cultural groups (see for an extensive review of the literature on this topic [66]). In reviewing a number of US studies on language barriers among Latino and Asian patients, Ramirez [4] found that linguistic barriers can lead to a number of negative consequences, such as an increased chance of non-compliance, feelings of fear and despair, and problems in achieving rapport. Moreover, the inability of patients to understand and speak the language of their physician may be an important obstacle in seeking care. His findings are supported by results of some European studies, which show that poor language proficiency is negatively related to patients’ perceptions of the quality of doctor–patient communication as well as to compliance [24,67].

Although it is beyond doubt that poor language proficiency will hinder adequate doctor–patient communication, the extent to which these linguistic barriers are the predominant factor in determining the quality of communication and care is not that clear-cut [68]. There is some empirical evidence indicating that other barriers play a more prominent role in intercultural communication problems. For example, informing ethnic minority patients in their own language does not improve compliance rates with preventive screening activities [69]. Besides, patients’ satisfaction with communication in health care is only partly related to their ability to speak the same language as the physician. Morales et al. [70] found that Latinos who spoke English were still less satisfied than White patients with doctor–patient communication, and Elsass et al. [71] found that, in spite of language difficulties and insufficient communication between 50 Greenlandic patients and their Danish therapists, patients were satisfied with received care. Patient satisfaction was related to perceptions of emotional factors such as doctors’ kindness and smiling faces, and not to linguistic problems.

The way the five aspects described above are related to intercultural doctor–patient communication is summarised in Fig. 1.

4.2. Study limitations

Due to the nature of our research questions, our review of the literature has some limitations. While we define intercultural health communication broadly, we limited our review to observational studies, because our primary aim was to research communicative behaviour. As observational methods yield the most reliable assessment of behaviour numerous studies on the topic of intercultural health communication were excluded, based on their methods. Thus, studies based on self-reports, surveys, in-depth interviews and the like were not included in our review. However, we did make use of the broader literature on intercultural health communication in the second part of this article. In doing so, our aim was not to give an exhaustive account of all available studies, but to identify key predictors of difficulties in intercultural health communication, because our aim was to be able to design a research model that may be used in future research on this topic. This approach did not make it feasible
to discuss each variable in detail. Detailed reviews on language variables do exist \[e.g. 4, 66\] but with regard to the other variables, much needed review studies still have to be carried out.

4.3. Conclusion

As is clear from our review study, the above-identified variables were not investigated at all in the studies under review, except for linguistic barriers. To be able to pin down the explanatory mechanisms beyond gaps in intercultural doctor–patient communication, future studies should start to incorporate these variables into their research designs and begin to integrate available knowledge and theories in the field of cross-cultural communication with those in the field of doctor–patient communication. Hopefully this will be a first step towards advancing our knowledge about the origins and solutions of gaps in intercultural medical communication.

In sum, the main conclusion of this review is that the extent of gaps in intercultural medical communication, its origins and the relationship between cultural variations in medical communication and health outcomes are still near-unexplored topics for research. Far more empirical research on the topic is needed, research that not only takes into account other observational strategies and communication variables such as doctors’ and patients’ non-verbal behaviour, but also tries to explain communication problems by incorporating theory-based variables such as the ones outlined in our research model. Closely related is the need to reach some consensus about what we mean by concepts as race, culture and ethnicity, why and how we think these concepts will influence medical communication, and how we should measure these relationships. Furthermore, a clearer sense of which problems are culture-specific and which are related to possible confounders of culture (i.e. social class, inequality in power, etc.) is needed as well \[72\]. In other words, we need to ask ourselves which aspects of doctor–patient communication are universal and which aspects are culture-specific, as culture adds just one more dimension to an already difficult communication situation.

4.4. Practice implications

In line with our conclusions, health care providers should keep an open mind regarding consultations with ethnic minority patients and need to reflect on the way differences in cultural values may play a role of importance in intercultural medical communication. Providers’ knowledge about patients level of acculturation and a good exchange of explanatory models are essential in achieving an adequate doctor–patient relationship. Furthermore, effective communication skills that expand language capabilities need to be enhanced. In this respect, more use could be made of migrant health educators employed as mediators to support the consultations of ethnic minority patients. Previous research has indicated that experiences in The Netherlands of GPs, patients and these link workers have been positive \[73\]. In sum, using a cultural sensitive approach by paying attention to the cultural variables as outlined in our theoretical model is recommended. Only by employing such a combined approach we will make every effort to decrease the extent of problematic communication in intercultural medical encounters.

References


