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

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2016

document version
Publisher's PDF, also known as Version of record

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 communication 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.