Strategies for Cross-Cultural Physician-Patient Communication: A Case of International Patients in a Cultural Competency Laboratory

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This thesis titled
Strategies for Cross-Cultural Physician-Patient Communication: A Case of International Patients in a Cultural Competency Laboratory

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ABSTRACT

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Strategies for Cross-Cultural Physician-Patient Communication: A Case of International Patients in a Cultural Competency Laboratory

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Healthcare for international populations in the U.S. has been challenged by cultural differences that arise during physician-patient communication. Numerous studies have assessed cultural competence training from physicians/health learners’ perspectives, but patients’ perceptions are underrepresented. This study bridges that gap by foregrounding international patients’ perspectives during a cultural competence training program, examining how cultural differences affect physician-patient communication, and proposing communication strategies that can benefit physicians/health learners and enhance the well-being of international patients. A three-phase case study that included focus group discussions, composite ranking, and in-depth interviews, was conducted focusing on a cultural competency laboratory, which took place at Ohio University in December 2012. Thirteen patients from eleven different countries participated in this study.

The results indicate that participants perceived significant cultural differences during their lab experiences, involving healthcare systems, health beliefs/concepts, healthcare seeking behaviors, and physician-patient communication. Among the twenty-eight factors in physician-patient communication that were raised by participants, active listening, explicit cross-cultural awareness, and expressive empathy were deemed to
facilitate physician-patient communication. In contrast, the interaction was significantly compromised when student-physicians ignored participants’ cultural perspectives, showed confusion/uncertainty about the medical issues that participants discussed, or didactically attempted to convince participants of certain American health beliefs or solutions. After attending the lab, all participants indicated an increased awareness of U.S. healthcare and the health issues discussed in the lab scenario. They also suggested that international patients get prepared before visiting U.S. physicians. This study provides suggestions for both physicians/health learners and international patients and recommends that more U.S. universities and communities provide programs that train international patients in their quest for optimal healthcare.
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Choosing to conduct this study was the boldest but also the most exciting decision that I have made during my Masters journey at Ohio University. I was amazed by the cultural competency laboratory at the Heritage College of Osteopathic Medicine, when I initially participated in it as an international patient in spring 2012. Since then, the idea of connecting this training with my specialization in health communication rooted in my mind. However, as a student without a medicine or public health background, I wondered how I should initiate this connection and develop defensible research. That was the biggest challenge I faced prior to beginning this study. Fortunately, I have received great help and unconditional support from many people. I would like to express my sincere gratitude to those who stood by me and gave me power along this unforgettable journey.

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CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

Healthcare for diverse international populations has become increasingly important in the U.S. In the early 1990s, communication problems were reported as the main cause of patients’ dissatisfaction with physicians (Richards, 1990; Simpson, Buckman, Stewart, Maguire, Lipkin, Novack, & Till, 1991). Now, in the early twenty-first century, rising globalization and migration have led to cross-cultural issues that complicate physician-patient communication in the U.S., where diverse ethnic minorities comprise 36.3 percent of the population (U.S. Census, 2010). Cultural differences between U.S. physicians and international patients can cause misunderstandings or discomfort during their communication, which may prevent physicians from adequately diagnosing a patient’s problem, and may discourage patients from properly following treatment or returning for a follow-up visit, thereby decreasing their health outcomes (Campbell, Sullivan, Sherman, & Magee, 2011). The physician’s or patient’s inability to recognize or address cultural differences intensifies racial/ethnic health disparities.

In an effort to reduce these health disparities, different physician-patient communication training programs have been applied in the U.S., which can help both physicians and patients raise their competencies in addressing health communication (Institute of Medicine, 2002; Hornik & Ramirez, 2006). Cultural competence training (CCT), for example, enhances physicians/health learners’ cultural sensitivity (Kleinman & Benson, 2006), while patient communication skills training (PCST) assists patients in seeking, providing, and verifying information when visiting physicians (McGee & Celaga, 1998). However, most CCT research evaluates only physicians/health learners’
training experiences, neglecting patients’ experiences (Cegala, 2004; 2006; 2009); cross-cultural issues were rarely addressed in PCST research (McGee & Celaga, 1998). Despite an increasing awareness of the importance of healthcare cultural competence, international patients’ perspectives in physician-patient communication training continue to be overlooked.

This study bridges that gap by focusing on international patients’ experiences while participating in a cultural competency laboratory at Ohio University. By conducting focus group discussions, a composite ranking, and in-depth interviews with thirteen international patients, this study examines how cultural differences affect physician-patient communication and what communication strategies can be employed to enhance healthcare for international patients.

1.1 Cultural Competence in Health Communication

Physician–patient communication research has a forty-year history (Korsch & Negrete 1972; Pendleton, 1982; Roter & Hall, 1989; Cegala & Broz, 2002). Kagawa-Singer and Kassim-Lakha (2003) examined the fundamental role culture plays in defining health, and how people of diverse backgrounds pursue wellness (Foster & Anderson, 1978; Angel & Thoits, 1987). Studying cross-cultural health issues can therefore help physicians understand patients’ perspectives and provide culturally suitable solutions. In addition to medical skills, scholars suggest that physicians improve their knowledge of “social and cultural issues”, “human behavior and development”, and “relationships” (Reena, 2005, p. 25).
Cultural competence is considered the core ability needed during cross-cultural physician-patient communication (Vijver & Breugelmans, 2008). Although no standard definition of cultural competence has been confirmed (according to the National Center for Cultural Competence), the concept has been widely applied (Horowitz, 2005). The report, *Toward a Culturally Competent System of Care* (1989) defined cultural competence as: “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis, & Issacs, 1989, p. 13).

Cultural competence has also been studied in nursing for over twenty years (Suh, 2004). The American Academy of Nursing defines cultural competence as “a complex integration of knowledge, attitudes, and skills that enhances cross-cultural communication and appropriate effective interaction with others” (Lenburg et al., 1995, p. 35). Because cultural diversity continues to increase, cultural competence is frequently emphasized by professionals in medicine, psychology, education, and social work (Suh, 2004). This characteristic is particularly needed in the interpersonal relationship between physicians and patients (Suh, 2004); cultural competence reflects the values of patient-focused care and further develops its mission (Campinha-Bacote, 2011).

1.2 Cultural Competence Training

Cultural competence has been incorporated into medical education and clinical practice during the past two decades (Weaver, 2008). Cultural competence training (CCT) has been applied in a wide range of medical services, including medical
interviews, home visits, counseling, and surgery (Silk & Weber, 2008; Reena, 2005; Campbell, Sullivan, Sherman, & Magee, 2011). Based on a large body of CCT research, to what extent have scholars examined CCT from both physicians/health learners’ and patients’ perspectives?

1.2.1 CCL Research from Physicians/Health Learners’ Perspectives

As a training model in medical education, CCT allows students to practice interacting with patients from diverse backgrounds. Griswold, Zayas, Kernan, and Wagner (2007) studied how medical students developed their cultural awareness while serving refugee patients from different cultures. Students were asked to assess the methods of interpretation they used; they reported an improved awareness of cultural diversity and an ability to adjust their cross-cultural communication. Similar training was also employed in home visits as a means of improving care for an aging U.S. population (Silk & Weber, 2008). In the study, 223 third-year medical students conducted half-day home visits with patients from foreign cultures. They then were asked to complete four tasks, in which they shared their home visit experiences, their opinions about home visit observation criteria, and their assumptions about patients’ cultural backgrounds. Students’ feedback acknowledged the benefits of attending this training and indicated overall improved skills in addressing cultural issues.

Despite the effectiveness of CCT, several studies have found inadequate cultural competence among medical students in other Western countries. Kai, Bridgewater, and Spencer (2001) conducted nine focus groups with fifty-five medical students in a UK medical school. Students were asked to discuss their understanding of multicultural
healthcare, their perceptions of current training techniques, and their preferred training process. Results indicated that students’ multicultural awareness was wide in scope but shallow in depth. Their lack of knowledge about different cultures suggested that CCT would be beneficial. Similar results were generated in Wachtler and Troein’s study (2003), which explored the potential of developing CCT into a medical program at Lund University in Sweden. Medical students were asked to interview patients during their preclinical terms. Afterward, small groups of students discussed their interview experience and shared their opinions about incorporating CCT into the current curriculum. Theoretically, students’ cultural competency could be evaluated during their existing practical examinations, but students reported that none of them had actually been examined on their cultural competency. Therefore, the CCT and a relevant examination system need to be developed.

CCT functions as an effective instruction tool in clinical practice. Hark and DeLisser (2009) compiled twenty-five clinical case studies that addressed cultural diversity “along with gender, language, folk beliefs, socioeconomic status, health literacy, religion, and sexual orientation” (Siegel, 2010, p. 68). Their interdisciplinary collaboration with forty-four physicians suggests that CCT can help deepen physicians/health learners’ understanding of diversity through daily practice (Siegel, 2010). Campbell, Sullivan, Sherman, and Magee (2011) conducted a survey with twenty-one resident physicians after they had participated in an international surgical mission, where they received training in serving patients in different cultural contexts. The majority assessed their mission experience as positive, mainly because it would benefit
their career. The results indicate the crucial role that overseas volunteerism can play in enhancing CCT in contemporary residency curricula.

1.2.2 CCT Research from Patients’ Perspectives

While the body of CCT studies regarding physicians/health learners is large, research rarely focuses on patients’ perceptions. Suh (2004) summarizes this imbalance: “historically, there has not been much attention given to patients’ cultural aspects due to positivistic biomedical perspectives… In contrast, awareness has recently increased about the need for physicians to possess knowledge and skills related to cultural competence” (p. 94). There has been a trend toward “the influence of patients’ cultural factors on their psychiatric symptoms, patient/physician relationships, and adherence to treatment” (Suh, 2004, p. 94). Farrelly and Lumby’s (2009) comprehensive review of CCT studies in the U.S. and Australia found very few efforts to examine the indigenous client or patient outcomes:

None of the studies reported in the literature identified for this review had evaluated the impact of CCT on Australian Indigenous client or patient outcomes. A review of the findings of American studies evaluating interventions to improve the cultural competence of health professionals conducted by Beach et al (2005) found that there is good evidence that cultural competence training impacts patient satisfaction, poor evidence that cultural competence training impacts patient adherence, and no studies that have evaluated patient health status outcomes. (Farrelly & Lumby, 2009, p.17)
In fact, only two studies discussed the effects of CCT from patients’
perspectives—and that was only one or two paragraphs in a full research paper! Lack of
evaluation of patient health outcomes after attending the training makes it difficult for
scholars to thoroughly learn the effectiveness of CCT.

1.3 Patient Communication Skills Training

1.3.1 Patient Participation

A modest body of research on patient communication skills training (PCST)
affirms that patient participation is highly valued. Patient participation is a process where
patients can provide information for, and seek explanation/suggestion from, physicians,
as well as to state their beliefs and express their concerns (Street, 2001). In practice,
patients who play a more active role when interacting with physicians usually feel more
satisfied, more in control of their health, and get better health outcomes (Griffin,
Kinmonth, Veltman, Gillard, Grant, & Stewart, 2004). Enhanced patient participation, on
one hand, encourages physicians to focus more on their patients (Cegala & Post, 2009),
on the other hand, promotes patients’ adherence to suggested treatments, referrals, and
follow-up visits (Cegala, 2006; Cegala, Marinelli, et al., 2000; Roter, 1977). Since PCST
trains patients in the communication skills they need to seek out, provide, and verify
information while visiting physicians, it plays an active part in enhancing patient health

1.3.2 Cross-Cultural Issues

Research on patient communication skills training (PCST) usually focuses on
general communication skills, while cross-cultural issues are not directly addressed. Of
nine PCST articles, for example, none directly discussed the concept of culture. Instead, racial/ethnic disparities were usually discussed as a side effect of cross-cultural issue (Cegala, Coleman, & Turner, 1998; McGee & Cegala, 1998; Cegala, Post, & McClure, 2001; Cegala & Broz, 2002; Cegala, 2003; Cegala, Gade, Broz, & McClure, 2004; Cegala, Street, & Clinch, 2007). In a review of twenty-seven PCST studies, fewer than half discussed patients’ racial/ethnic backgrounds and only three studies discussed the effects of communication interventions on patients from diverse cultures (Cegala & Post, 2006). This lack of research suggests that scholars pay scant attention to cross-cultural issues in PCST and that minority patients gain less from PCST (Cegala, 2006).

Patients’ cultural competence is discussed only briefly in few studies. In Harmsen and colleagues’ study (2005), for example, the influence of cross-cultural communication intervention on both patients and physicians was examined through 986 consultations, where general practitioners were educated about cultural differences and cross-cultural communication skills. Later on, a group of non-Western patients watched a video about properly communicating with their foreign physicians. Six months after this training, mutual understanding between patients and general practitioners had increased, as had patient satisfaction and their compliance with suggested treatment (Harmsen, Bernsen, Meeuwesen, Thomas, Dorrenboom, Pinto, & Bruijnzeels, 2005).

1.4 Analysis of Research Gaps

According to the literature review, there are two unfortunate gaps in research on physician-patient communication training programs. First, most CCT researchers examined physicians/health learners’ perspectives, whereas international patients’
training experiences and perceptions were rarely discussed. Undeniably, physicians/health learners’ perspectives provide valuable information, but they do not reflect the entire physician-patient relationship. During the CCT, for example, some physicians/health learners tried to interpret patients’ perception through their facial expressions and manners of talking. Their judgment, however, mostly remained as assumptions that could be inaccurate and even wrong, because many physicians/health learners lacked sufficient knowledge about different cultures and they did not check their assumptions with their patients. In some training programs, medical students were mere observers of physicians’ interactions with patients in clinical encounters. There is much room for misunderstanding in such indirect observation, as medical students are not communicating directly with patients.

Second, research on patient communication skills training focused on general communication skills, rather than training international patients in communicating with Western physicians. Compared to the cultural competence training provided to physicians, this imbalance confirms that patients’ role in communication is grossly underestimated.

If physician-patient communication training is designed to help physicians better understand and treat patients (Kleinman & Benson, 2006), then patients’ experiences must be an integral part of the training. Only when their needs are addressed and understood, can patients feel satisfied with the service and properly comply with physicians’ suggestions. The only way to accurately understand their perceptions is to interview the patients.
1.5 Research Questions

This study aims to bridge the gaps discussed above by addressing the following questions:

**RQ1:** What cultural differences do international patients perceive during a cultural competency laboratory?

**RQ2:** How do these differences affect physician-patient communication?

**RQ3:** What communication strategies can be implemented to resolve these cultural differences?
CHAPTER 2: METHODOLOGY

2.1 Study Setting

This study focused on a skills-oriented cultural competency laboratory (referred to as “lab” below), specifically designed for Ohio University Heritage College of Osteopathic Medicine (OU-HCOM) students to improve their cross-cultural communication skills. This lab was initiated nine years ago (during 2004-2005) by Dr. Judith Rhue, a professor in the Department of Family Medicine; she has directed the communication labs for first and second year medical students for over 20 years.

The cultural competency lab took place on December 4th and 6th of 2012 at the Clinical Training and Assessment Center. Each lab session lasted four hours per day and included a series of fifteen-minute mock medical interviews, where medical students acted as physicians and international participants acted as patients. All medical interviews took place in eighteen fully outfitted examination rooms. The lab was directed by Dr. Rhue and coordinated by Ms. Pam Henderson, the Supervisor of the Clinical Training and Assessment Center.

2.2 Participants in the Laboratory/Current Study

The lab and my study took place separately, and my participants were recruited by different means. The lab participants included one hundred thirty second-year OU-HCOM student-physicians and fifteen international participants (thirteen OU students and two people from the community). They were recruited by the Clinical Training and Assessment Center through email, word of mouth, and Facebook and paid $60 by the Center to attend each lab session. During the lab, international participants played their
roles as “patients” (referred to as “participants” in my study) by interacting with student-physicians (referred to as “students”) in a given case scenario.

I recruited the participants for my study directly from the lab’s briefing prior to the lab beginning¹. While student-physicians’ performances were discussed, they were not recruited to participate in my study. Thirteen of the fifteen international participants volunteered to take part in my study, nine of whom were female. They represented eleven different countries, including Bangladesh (n=2), China (n=1), India (n=2), Sri Lanka (n=1), and Thailand (n=1) in Asia; Ghana (n=1), Kenya (n=1), and Nigeria (n=1) in Africa; and Chile (n=1), Colombia (n=1), and Venezuela (n=1) in South America. Of the thirteen participants, eleven participated in the focus group discussions (eight female and three male), eight took part in the composite ranking (six female and two male), and nine participated in individual in-depth interviews (seven female and two male).

2.3 Laboratory Case Scenario

Prior to each lab session, Dr. Rhue conducted a twenty-minute briefing to participants about their case scenario and provided instructions (see Appendix A for the complete Case Scenario). In the scenario, a patient visits a doctor (acted out by medical students) with feelings of fatigue and sadness. Complete work-up results indicate that the symptoms are not due to physical illness and seem to be depression. After explaining the situation to the patient, some of the student-physicians suggest that the patient visits a psychologist/psychiatrist for depression as a solution to this health issue. During the medical interview, participants were expected and encouraged to apply their own cultural

¹ Those who volunteered to participate in my study signed a consent form. Confidentiality of responses was maintained.
perspectives in their improvised response to the student-physicians. The student-physicians were then expected to address those cultural differences and provide culturally acceptable and helpful solutions.

2.4 Procedures and Instruments

I conducted a three-phase case study, which included semi-structured focus group discussions, a composite ranking, and individual semi-structured in-depth interviews. Method triangulation was used to decrease any bias that might result from a single method (Thurmond, 2001; Mitchell, 1986).

❖ Phase 1. When the lab ended on both days, a forty-five-minute focus group discussion was facilitated by the Supervisor of the Clinical Training and Assessment Center while I took notes. Five patients participated in the discussion on December 4th and the other six patients participated on December 6th. Topic guides were used to encourage participants to discuss their lab experiences and to evaluate the student-physicians’ performance (see Appendix B for the Focus Group Discussion Protocol). The discussions were audio-recorded with the participants’ consent and were thematically transcribed.

❖ Phase 2. A composite ranking was conducted to identify factors that participants perceived influential in physician-patient communication during this lab (Babbie, 1995). First, each participant wrote down three positive factors and three negative factors that influenced their lab conversations (see Appendix C for the Ranking Form). Then, in a separate document, I compiled two lists of all positive and negative factors. Each participant then ranked the top five positive factors as well as negative
factors from both lists by scoring from “1” to “5”, with “1” being the most influential and “5” being the least influential. In calculation, the total rank of each factor was the sum of scores it received, and its mean rank was the result of dividing its total rank by the number of participants who scored. Overall, the lower mean rank one factor had the more influential it was. Factors scored by fewer than two participants were disregarded.

Phase 3. I conducted a series of thirty-to-fifty-minute individual in-depth interviews with nine participants at the university library. In accordance with participants’ suggestions in the focus group, the interview protocol was revised to be more specific (see Appendix D1 and Appendix D2 for original and revised In-depth Interview Protocols). Besides topics discussed in the focus group, participants were asked to describe how they depicted the health issue (depression) during the lab and to suggest the ideal communication strategies that student-physicians might employ. The discussions were audio-recorded with participants’ consent and were thematically transcribed.
CHAPTER 3: RESULTS

The cultural competency lab offered medical students and participants a unique experience given its training approach and its culturally-contextualized scenario. Both students and participants were asked to play a simulated role during this lab, but their performances were analyzed with different expectations in this study. Because medical students are currently health learners who lack experience of practicing independently (although they have the opportunities to interact with patients during their college education), it would be unfair to expect them to perform as professionally as experienced physicians. Thus, discussing medical students’ performances in this study is not to judge their proficiency, but to explore strategies for addressing similar issues that other physicians/health learners may encounter in actual healthcare. Although some participants inevitably compared medical students with physicians in their countries, my intention is to reveal cultural differences in communication and to share helpful experiences/lessons that can inspire and inform health learners and physicians. In contrast, international participants were able to represent themselves, as they all had been a patient before and their experiences in living in the U.S. helped them enact the illness. Thus, participants’ lab experiences could be used for physicians/health learners to learn about common issues in communicating with international patients.

In this lab, “depression” was a well-chosen case scenario that provided a specific context for participants to share their cultural perspectives, which is different from other regular/physical illnesses. First of all, this is a mental issue that is difficult for physicians to diagnose or for international patients to recognize, following a standard definition.
Because of the unique social norms in each country, people from different cultures have developed their own manners of expressing emotions and interpreting other people’s emotions. As a result, people who may seem to be depressed in one culture might be considered normal in another culture, and vice versa. This explains why participants reacted differently to the student-physicians’ diagnosis of their depression-like symptoms. Moreover, although the symptoms of depression (e.g., fatigue and sadness) can be universal, the ideas of naming this mental disorder and labeling people with depression are not worldwide. While depression is commonly accepted in the U.S., it carries a strong social stigma in many other cultures (e.g. some Asian, African, and South American cultures). Given people’s uneven knowledge about depression and different social attitudes toward this issue, the solutions people apply to address this issue vary from culture to culture. This affected participants’ perception/performance of depression and compliance with the student-physicians’ suggested solutions.

Given the cultural specificity of depression, participants were eager to share their different perspectives while interacting with the student-physicians. Although the lab scenario was simulated, all participants drew upon their personal experiences while depicting depression. In fact, eighty-two percent of the participants experienced difficulties in transitioning to the U.S., such as stress from schoolwork, adjustments to the education system, local climate, food, loneliness, homesickness, lack of social/family support, separation from partner, and relationship issues. Six participants who had depression-like symptoms/experiences shared a large proportion of real-life content in their stories while depicting depression (approximately seventy to ninety percent,
estimated by participants); the seven participants who had no depression or seldom felt
depressed shared much less real-life content in their stories (approximately eight to fifty
percent). Participants’ real-life stories enabled the student-physicians to learn about
international patients’ perceptions and common situations that might affect their mental
health. When evaluating their lab experience, eighty-five percent of the participants
believed that this lab could benefit both international patients and medical students by
educating them about cultural differences. Since both sides are aware of possible
conflicts in cross-cultural physician-patient communication, they can improve their
communication strategies to address cultural issues, thus avoiding misunderstanding that
might negatively affect their health outcomes.

Participants reported that this lab experience had a significant influence on their
knowledge and health beliefs. Most of them had increased knowledge about depression.
By checking upon the symptoms they learned about, some participants realized that they
probably had been depressed in the past and now they understood its cause. The solutions
they learned from student-physicians enabled them to manage emotional problems on
their own as well as to help people with similar issues. This experience also affected
participants’ health beliefs. Those who viewed depression as a severe problem (e.g.,
insanity) and were against seeing a psychologist/psychiatrist now realized that depression
is a common condition and they would consider visiting one if needed. “Although it’s a
mental condition, it’s not the end of the world,” a Nigerian participant said, who
previously believed that depression is “crazy” and seeing a psychologist is “very
strange.” Participants thus gained a better understanding of healthcare in the U.S. and
learned more about American culture. One participant appreciated the opportunity for evaluating student-physicians’ performances, which patients are rarely able to do in actual healthcare. Another participant suggested that more U.S. universities provide such training for international students. All participants would attend another cultural competency lab in future and most of them would recommend this to their international friends, because they considered it necessary to learn how to visit U.S. physicians.

Participants also evaluated the student-physicians’ performances in relation to their cultural backgrounds and gender. Overall, there was no obvious difference between American and non-American student-physicians’ performances. It is possible that non-American students were more likely to acknowledge international participants’ feelings because they shared similar cross-cultural experiences. In fact, some non-American student-physicians did not show as much empathy to their participants as American student-physicians did. Even a student-physician and a participant who came from the same country did not have a successful interaction, because the student did not acknowledge the participant’s feeling as expected. However, this is not necessarily a manifestation of being unprofessional, since student-physicians’ uneven performances can be caused by their unique personalities and different social expectations of physicians in their home cultures. Perhaps keeping patients at a proper distance is considered professional and acceptable in some cultures. In addition, language barriers slightly affected physician-patient communication, since few non-American students’ accents were problematic for some participants.
There is a slight imbalance in the distribution of student-physicians in terms of gender. Some participants met all-female or all-male student-physicians during the rotation, and they would have liked the opportunity to interact with a different gender. Although most participants believe that gender did not play a significant role, some tended to assume that female physicians are generally more empathetic and understanding. Some female participants felt more comfortable visiting female physicians for sensitive health issues (e.g., gynecology).

In the composite ranking portion of my research, participants rated influential factors that either facilitated or compromised physician-patient communication. In both focus group discussions and in-depth interviews, participants compared the healthcare systems in the U.S. with their home countries and discussed the cultural differences they perceived between them and the student-physicians. According to their lab experiences, cultural differences were a definite challenge in physician-patient communication. While some of the student-physicians explicitly acknowledged these differences, others failed to address the cross-cultural issues that occurred. In the in-depth interviews, participants further described the influences of cultural differences on their communication with student-physicians and their ideal qualities in a physician. Below, I present the specific research results in four subsections: influential factors in physician-patient communication, perceived cultural differences in healthcare, influences of cultural differences on physician-patient communication, and student-physicians’ performance in addressing cultural differences.
3.1 Influential Factors in Physician-Patient Communication

In the composite ranking, participants listed fourteen positive factors and fourteen negative factors that influenced physician-patient communication during the lab. In the second round of ranking, they rated the top five positive factors and negative factors together. According to the ranking results, active listening between student-physicians and participants, thoughtfulness about participants and their cultural perspectives, and expressive empathy were the top three factors that facilitated the lab communication most (see Appendix E1 and Appendix E2 for detailed ranking results). In contrast, physician-patient communication was significantly disturbed when students 1) ignored or were unable to acknowledge participants’ perspectives, 2) expressed confusion/uncertainty about the medical issues that participants were discussing, and/or 3) didactically tried to convince participants of certain American health beliefs or solutions.

The six significant factors mentioned above are actually connected, because they all reflect the international patients’ crucial needs. On one hand, like every patient, they need physicians’ attention to their health issues and understanding of their suffering. On the other hand, as international clients, they also need physicians to respect and actively engage their cultural perspectives. While the situations described in these factors are not exclusively culturally-bounded, as they can occur between U.S. patients and physicians as well, it is significant to discuss these factors in this context because their influences can be reinforced by cross-cultural conflicts.

Another negative factor, “students frequently checking their scripts”, was initially rated as the second-most influential factor, but was disregarded because this item
involves no explicit cross-cultural issues and hardly applies to actual healthcare, since the student-physicians’ scripts were a simulation tool used only in this particular training process but will rarely be used in actual healthcare. Other four positive factors and three negative factors were disregarded, because fewer than two participants scored them. The four positive factors are: 1) warm greetings from both parties (student-physicians and participants), 2) awareness of stigma attached to health issues, 3) a range of options offered to patients, and 4) willingness to help patients. The three negative factors are: 1) an inability to understand patients’ speech, 2) chuckling at patients’ inquiries, and 3) offering no physical checkup.

Participants’ giving a low ranking to the factors listed above can be explained by two reasons. First, it is possible that most participants believe that these factors have the least influence on physician-patient communication. This is somewhat reasonable because very few participants experienced the situations described by these factors or prioritized them as influential (e.g., “chuckling at patients’ inquiries” and “offering no physical checkup”). However, many of the factors with low ranking reflect participants’ common experiences, and even shared similarities with factors that received high ranking. For example, the positive factor, “students’ awareness of stigma attached to health issues” reflects a specific aspect of the highly ranked factors, “students’ awareness of differences” and “both parties’ awareness of cultural differences”. Likewise, the second-most influential positive factor, “students’ thoughtfulness” is actually a generalization of several poorly ranked factors that present specific situations. Why did participants give a low ranking to factors that are similar to factors that are highly
ranked? It indicates that participants prioritized a factor that was phrased in a general tone, perhaps because they were required to select only five most influential factors. Choosing a generally-phrased factor allowed them to cover multiple specific situations. In this case, receiving a low ranking does not mean that these factors were not influential.

3.2 Perceived Cultural Differences in Healthcare

Participants experienced significant differences while interacting with the student-physicians. They found the U.S. healthcare system to be very different from that in their home countries. This involved the way hospitals operate, health insurance and billing policies, healthcare procedures, and service quality. Participants’ discussions indicate that both healthcare system and culture play a fundamental role in shaping individuals’ health beliefs, healthcare seeking behaviors, and physician-patient communication. Participants’ health beliefs about depression, approaches of addressing depression in their home countries, and perceived differences in physician-patient communication are discussed below.

3.2.1 Health Beliefs about Depression

In the eleven countries the participants come from, depression is not a common concept. For example, depression rarely emerges as a conversation topic in India. Instead of saying, “I am depressed,” people will mildly say, “I am upset” or “I have tension.” In fact, in these Asian, African, and South American countries, there is a strong social stigma attached to depression. People who have depression are likely to be labeled as “crazy” and “abnormal” outcasts who “have serious issues,” even by their family or friends. Thus, it is very difficult for people from these countries to accept depression as a
“normal” medical diagnosis. Even in this simulated case, when participants were asked to behave as though they were depressed or when they were told by the student-physicians that they were diagnosed with depression, their immediate reaction was that of alarm: “What? Is there something wrong with my mind?!” “Do you mean I am crazy?!"

Depression is also considered age-specific in some cultures. According to a Kenyan participant in her twenties, people in Kenya would not take it seriously if she says she is depressed, because they believe that it occurs only to elders and that young people have nothing to complain about.

3.2.2 Healthcare Seeking for Depression

Because of the cultural stigma attached to depression, it is unusual and even taboo to see a psychologist or psychiatrist. As a result, people mostly visit physicians only for physical problems. For emotional distress, people follow different procedures. A participant from Sri Lanka believes that meditation helps people focus and decrease stress. In India, Nigeria, Ghana, and Venezuela, a strong support system from family and friends mitigates depression, by talking, hanging out together, and going with the depressed person to see a physician. These social networks help divert patients from their negative emotions. However, this social support all but disappears when they arrive in a foreign country. It is difficult for them to fully rely on people they do not know well. Thus, for example, when the student-physicians suggested that participants share their emotional issues with American acquaintances, some participants were reluctant to do so, because they were uncertain if people here would be discreet and/or misunderstand them.
When medication was suggested for treating depression, some participants strongly preferred alternative therapy and home remedies, because they believe that Western pharmaceuticals produce unpleasant and potentially dangerous side effects. They were accustomed to traditional medicine as a crucial component of their national healthcare system, and were surprised to find it unavailable in the U.S.

3.2.3 Physician-Patient Communication

Participants experienced a very different relationship with the student-physicians than with the physicians in their home countries. These differences involved greeting styles, conversational atmosphere, time, engagement, and patients’ input. Many participants appreciated the respect the student-physicians showed them by giving a warm greeting and handshake, which was perceived the first difference in communication style since physicians seldom do so at home. Participants also appreciated the more relaxed conversational atmosphere, as student-physicians talked with them in a casual manner and listened to them with a smile and patience. This encouraged participants to open up and tell their stories. In contrast, physicians in some countries (e.g., Kenya and China) were perceived as more formal, because they usually talk in a serious tone and seldom smile, thus discouraging patients from expressing their concerns.

The limited available time for doctor visits is another factor affecting patients’ engagement. In Bangladesh, India, Kenya, and Sri Lanka, most people go to public hospitals that provide low-cost service. Because many patients are examined per day, physicians in public hospitals tend to keep each interview short and patients usually feel too rushed to talk about their cases in detail. For instance, people in Kenya usually get no
more than ten minutes to speak with a physician, so a Kenyan participant initially felt overwhelmed about processing each lab interview for fifteen minutes. She was surprised to find that the student-physicians were so caring, and she interacted with them very well without noticing the time.

Many participants were impressed by the number of options that student-physicians recommended, and their willingness to answer patients’ questions. As two participants from India and Bangladesh noticed, physicians back home usually offer treatments and prescriptions without explaining much. Many Indians regard physicians as god-like, and with full trust, so they follow physicians’ orders without asking questions. Compared to the dominant role that physicians play in these countries, the student-physicians encouraged participants to ask questions and provided thorough explanations. They also left options open for participants rather than pushing them to adopt certain treatments. Therefore, participants performed more actively in seeking information and making decisions rather than passively following the student-physicians’ words.

3.3 Influences of Cultural Differences on Physician-Patient Communication

3.3.1 Language Barrier Impeded Understanding

Although most participants are relatively proficient in English, one of their primary concerns is the language barrier that international patients may face while communicating with U.S. physicians. In fact, some participants had difficulties following student-physicians who spoke too fast, used a lot of medical jargon (e.g., “stigma”, “melatonin”, “neurologist”), or used colloquial expressions. One participant recalled that her student-physician explained depression by saying, “What happened is when your
brain starts firing different signals…” She tried to make sense of the sentence by catching keywords such as “brain” and “firing”, but could not figure out the connection between them.

3.3.2 Social Stigma Complicated Physician-Patient Communication

Because depression is stigmatized in many cultures, some participants were sensitive about the way student-physicians casually announced their diagnosis. A participant from Nigeria had an uncomfortable conversation with the student, who straightforwardly announced at the beginning, “I understand that you have depression.” This participant was shocked and found it difficult to accept such an abrupt announcement. Another stigma some participants tried to avoid was the student-physician’s passing judgment on their lack of English proficiency. A Bangladeshi participant said that she sometimes could not understand the student-physicians’ speech, but hesitated to ask them to explain or slow down, because she was afraid that the students would think she could not understand “even such an simple word.”

3.3.3 Conflicting Health Beliefs Affected Patients’ Compliance

Because participants have different cultural beliefs about depression and its treatment, many of them rejected student-physicians’ suggestions, such as taking medication, visiting a psychiatrist/psychologist, or joining support groups. When a Thai participant was told that she should see a psychiatrist, she immediately said that it is not acceptable in Thailand. However, the student-physician kept saying, “It is okay to see a psychiatrist,” without addressing the participant’s concern. The participant understood that the student-physician wanted to tell her that seeing a psychiatrist in the U.S. is
acceptable, but the way of talking did not remove her concern about the social stigma. Cultural conflicts like this can prevent patients from properly following a physician’s suggestions or prescriptions.

3.3.4 Careless Speech Can Be Offensive

Because people understand and interpret things differently from different cultural perspectives, the participants were sometimes offended by the student-physicians’ words although they meant no harm. For example, after a female participant told the student-physician that she felt unhappy, the student immediately asked, “Do you have a boyfriend?” This question offended the participant because the student presumed that she had personal relationship issues. Although she understood that the student’s intention was to help, she nevertheless felt uncomfortable being asked such a personal question. Many participants appreciated the student-physicians’ informal communication style because it helped them relax and open up. However, being too casual was perceived as offensive. For example, when a participant asked a student-physician to give a simpler example, the student murmured, “Wow, what can be simpler than this?!” The participant was offended by this student’s lack of respect. In other cases, participants felt marginalized when the student did not introduce him/herself, chuckled after the participant asked a question, and/or joked while talking about the participant’s condition.

3.4 Student-Physicians’ Performance in Addressing Cultural Differences

3.4.1 Language Adjustment

In order to avoid misinterpretation, some student-physicians spoke more slowly than usual and used “normal” language instead of medical jargon. Some students did well
by regularly confirming participants’ perceptions. For example, some paused after introducing a new concept and asked, “Do you understand what this means?” and “Are you able to follow me so far?” Some repeated what participants said to ensure they understood everything correctly. Such efforts are appreciated because it indicates that participants’ language needs are acknowledged. If a participant-student pair share a language other than English, the student-physician can create a common bond by speaking the participant’s language, even if they come from different countries. A participant from Venezuela had a pleasant conversation with a Russian student-physician who was learning Spanish. After discovering that the participant’s native language is Spanish, this student attempted to speak Spanish, which made the participant’s happiest moment during the entire lab. However, this did not always happen between student-physician and participant from the same country. Two participants from China and Colombia both met student-physicians from their home countries in a previous cultural competency lab, but neither of the student-physicians initiated the “mother tone talking” with these participants, although it would be easy for them to recognize their compatriots by their appearance and accent.

3.4.2 Etiquette and Respect

Since every culture follows different etiquette, the participants expected that their own style of manner could be respected. Cultural sensitivity enabled some student-physicians to notice such cultural differences and to adjust their behaviors accordingly. For example, physicians and patients in Thailand do not shake hands, especially between the opposite sexes. One female Thai participant, thus, intentionally did not shake hands
with the student-physicians she met. One male student noticed this intentional sign, so he did not initiate the handshake. Instead, he gestured with his hands, indicating that she should sit. This participant felt affirmed by the student who obviously understood and considered her cultural needs.

Respect can be signified by body language. For example, it is easier for participants to open up to student-physicians who showed respectful postures (e.g., smiling, a welcoming handshake, leaning in towards participants, listening with full attention, and appropriate eye contact). In contrast, some body language created distance and indifference (e.g., showing an emotionless or serious face, sitting far away, leaning back in the chair, and crossing arms while talking). In addition, student-physicians who avoided eye contact and frequently touched their hair, clothes, or shoes signified nervousness and/or lack of confidence to the participants.

3.4.3 Empathy and Emotional Acknowledgement

Participants tended to establish stronger attachments with student-physicians who understood their situations and acknowledged their emotions. Three participants shared positive experiences, where the students acknowledged their homesickness and loneliness. For example, some student-physicians shared similar feelings when they were away from their families. One student said, “I totally understand. Just imagine if I go to a new country, I will feel the same, so you are not alone.” After a Bangladeshi participant expressed her concern about seeing a psychiatrist because of the stigma, the student confided to her that, because he is from an African country, he understood her situation. Emotional acknowledgement made the participants feel less isolated, so they were more
inclined to share descriptive information and felt more confident with the student-
physicians.

3.4.4 Accepting Cultural Differences and Addressing Patients’ Health Beliefs

Most student-physicians were open to participants’ different cultural perspectives
and health beliefs and they actively looked for alternative solutions that are culturally
easier to accept. When participants felt uncomfortable taking medication or seeing a
psychiatrist/psychologist, many student-physicians offered options that had fewer side
effects and carried no stigma (e.g., exercise, support from friends, healthy diet). For
instance, when a participant from Sri Lanka said that he preferred to use medication from
home, a student-physician volunteered to talk to a physician in Sri Lanka and check if he
could get medicine from there for the participant. The participant was very impressed by
this creative and thoughtful response.

Considering that participants do not want to be stigmatized with the label of
“depression”, some student-physicians strategically announced the diagnosis by
substituting “depression” with another word. For example, when a student-physician was
told by a female participant that people in India seldom use the word, “depression”, he
said, “Okay, if you don’t want to call it depression, we don’t have to call it that.” Instead,
he said, “all your feelings.” The participant felt more comfortable talking with this
student compared to others who did not change their designation, because his empathetic
communication style distanced her from stigma.
CHAPTER 4: DISCUSSION

Based on participants’ perceived differences in physician-patient communication, the first part of this section discusses several factors that can cause these differences and influence the physician-patient relationship. The second part explores two controversial issues that raised ethical dilemmas for both student-physicians and participants. In addition to educating student-physicians, eighty-nine percent of the participants believe that it is necessary for international patients to prepare themselves before they visit U.S. physicians. Suggestions for physicians/health learners and international patients are discussed in the third part.

4.1 Factors Causing Differences in Physician-Patient Communication

Most participants said they played a more active role in physician-patient communication than they did in their home countries. Participants’ engagement was encouraged by sufficient time for communication, informal conversation, and student-physicians’ respect. What explains these health communication differences? Below, I discuss several social, cultural, and economic factors.

4.1.1 Distribution of Resources

Resources that may affect healthcare quality include budget, time, facilities, and other elements. In developing countries, a lack of resources forces physicians to compromise both the time and the quality of their service, thus putting constraints on the physician-patient relationship. For example, most patients choose low-cost services at public hospitals because they have a limited budget and physicians must shorten each interview by rushing their patients. Patients are therefore unable to communicate with
physicians sufficiently, which decreases patient satisfaction and intensifies the physician-patient relationship.

4.1.2 Power Distance

Within a social structure, power distance determines the extent to which people at different power levels accept and expect to be unequally viewed and treated (Hofstede, 2001; Hofstede & Hofstede, 2005). In a society where power distance is large, social hierarchy is stressed and people are expected to behave according to their social status and show respect to people with a higher-level status. In the healthcare context, power differences can be partly attributed to resources, knowledge, and authority. Thus, physicians who have professional medical skills have more power than patients who lack these skills. In some Asian countries, for example, physicians are viewed as authorities whose opinions should not be questioned. Patients, who are considered unprofessional, should obey physicians. As a result, patients are accustomed to following physicians’ orders and even lose the willingness to make their own decisions. In the physician-patient relationship, physicians play a dominant role and patients are less engaged. This faith in physicians’ authority can be reinforced by religious beliefs in some countries (e.g., India), where physicians are regarded as god-like.

4.1.3 Consumer Awareness

Patients, in a sense, are consumers because they are paying for the services provided by physicians. An awareness of being a consumer can encourage patients to make full use of their rights, request quality service, and play an active role in the physician-patient relationship. However, consumer awareness is not yet well established
in some developing countries. For example, since public healthcare in India, Bangladesh, and Sri Lanka is mostly paid for by the government, patients are less likely to view themselves as consumers, and so do not fully understand their rights, and physicians perceive less pressure to improve their service. This leads to the patient’s passive position in the physician-patient relationship.

To summarize, the physician-patient relationship is deeply influenced by the distribution of resources, social structures, cultural traditions, and people’s awareness of their roles and rights as consumers.

4.2 Ethical Dilemmas

4.2.1 Personal Questions

Participants had conflicting opinions about personal questions asked by student-physicians. An Indian participant enjoyed being asked about her background (e.g., “Where are you from?” and “What recently happened in your life that might have caused your problem?”), because it made her feel more like a person rather than a medical object. A casual chat before the medical interview also helped other participants relax. However, a Nigerian participant felt uncomfortable when a student-physician asked her personal questions (e.g., “What program are you in?” and “Where do you work?”), because they were irrelevant to her condition. During the ranking, half the participants ranked “students’ asking personal questions” as a negative factor that disturbed physician-patient communication. The mean rank of this factor was above medium (n=4), which means this behavior was not very influential. Given that not the majority considered asking personal questions to be negative, the influence of this behavior should
be judged case by case. Personal questions that can help health physicians/health learners learn about patients’ cultural background and perspectives are acceptable, whereas questions involving patients’ privacy that are entirely irrelevant to their condition are not helpful and can offend patients. In terms of time, it is better for physicians to keep this “warm-up chat” brief within minimum questions.

4.2.2 Patients’ Options Vs. Physician’s Advice

Providing suggestions was a very challenging step of the lab conversation, because culturally conflicting health beliefs kept many participants from accepting student-physicians’ suggestions. Whether to cater for patients’ preference or to persuade patients to follow the necessary procedures reflects a dilemma for physicians playing their roles in the physician-patient relationship. It tests physicians’ ability to find a balance between directing patients and respecting their cultural perspectives.

Facing a participant’s objection, most student-physicians were able to provide alternative suggestions, such as lifestyle adjustment and enhancing social contact. Their willingness and ability to provide alternatives was appreciated by many participants. As a result, most participants followed students’ suggestions after they explained their cultural perspectives and reached a mutual understanding.

However, another dilemma emerged when some participants presented severe symptoms that weakened their judgment and really needed medical attention, but they kept refusing medication or seeing a psychiatrist. In order to “challenge” students, for example, a Bangladeshi participant intentionally acted as a suicidal patient who refused medication or counseling. In this extreme case, most students chose a mild solution—
followed the participant’s preference and suggested her to start with a lifestyle adjustment. This certainly took care of the participant’s preference, but this participant doubted that merely changing lifestyle, which works for on-set depression symptoms, could effectively help a suicidal patient. She suspected that student-physicians did so because they were trained to respect participant’s opinion, but saving patients’ life should be more urgent than pleasing patients’ emotion. She believe that it is necessary for student-physicians to explain the severity of conditions to the patient and stress the importance of taking necessary treatment, even if the patient does not prefer it.

Similarly, an Indian participant sensed that some student-physicians hesitated to make a specific decision for the participants. She asked several students what the best solution would be for her, but few students answered with certainty. Interestingly, these two participants said in the focus group that they appreciated students who provided multiple options and allowed participants to make choices. What they said seemed to be contradictory to their own opinions, but actually they were commenting on different situations. In general, they appreciated that student-physicians took care of participants’ perspectives by offering options, but they also stressed physicians’ primal responsibility—to save the patient’s life. Therefore, it is necessary for physicians to help patients identify the best solution, when patients are unable to make the right choice because of their knowledge limit or health conditions.
4.3 Suggestions for Physicians/Health Learners

4.3.1 Take Care of Language Barrier

It is necessary for physicians to adjust their speech while talking to international patients whose English is their second or third language. It is helpful here to view language as a tool for communication rather than a proof of the physician’s expertise. Thus, physicians should use easy-to-understand language/expressions and speak more slowly when needed. It is better for them to refrain from using medical jargon and use simpler synonyms, analogies, and clear explanation. They must be careful of colloquial language as well. Physicians can check with patients while introducing a medical concept. They can also repeat patients’ words to confirm that they understand what the patients mean. If the patient and physician can speak a common language other than English, the physician can create a more comfortable context by speaking the patient’s language.

4.3.2 Respect Cultural Differences and Address Patients’ Health Beliefs

Because cultural differences are unavoidable while working with international patients, physicians need to accept patients from diverse backgrounds and keep minds open to different health beliefs. Physicians can ask about the patients’ cultural backgrounds before the formal medical conversation begins. When discussing the condition with patients and providing suggestions, physicians need to consider the patients’ perception and they can choose substitute words to avoid using words that might carry stigma. If patients are not comfortable with certain treatments, physicians ought to be able to offer alternative solutions according to patients’ cultural preference, or help
patients understand why the suggested treatments are necessary by providing education. Physicians should interact with patients in a manner that is proper and respectful in the patients’ culture. In order to present themselves properly, it is important for physicians to learn about different cultures and etiquette, which can be done by reading, meeting international people, studying foreign languages, and attending cultural competency training programs.

4.3.3 Show Empathy and Emotional Acknowledgement

Many international people experience adjustment challenges while living in the U.S., such as homesickness, loneliness, a new educational/occupational system, culture shock, isolation, and language barriers (Heggings & Jackson, 2003; Olivas & Li, 2006). Thus, they are vulnerable to mental health issues and crave empathy and emotional support from the physicians (Nilsson, Berkel, Flores, & Lucas, 2004). It is important for physicians to listen carefully with patience when patients explain their problems and to encourage patients to share their feelings. Physicians need to show understanding to patients’ situation/suffering. They can acknowledge patients’ emotion by sharing their similar feelings and experiences. Physicians’ empathy can help patients establish the confidence to fight with their problems.

4.3.4 Use Positive and Respectful Body Language

Participants appreciated student-physicians’ positive body languages that conveyed warmth, acceptance/understanding, interest, respect, and encouragement. Positive postures that can help patients relax and open up include smiling, nodding head, a handshake with moderate strength, leaning towards patients while sitting, listening with
full attention, and respectful eye contact. Physicians should avoid body language that can create a sense of disrespect or indifference, such as showing emotionless face, sitting far away from patients, leaning back on the chair, and crossing arms while talking. In some Asian cultures, showing the bottom of one’s shoes is considered insulting. In order to avoid misunderstanding, physicians need to learn about meanings of basic body languages in other cultures.

4.4 Suggestions for International Patients

4.4.1 Improve Cultural Awareness and Learn About U.S. Healthcare

Same as physicians, patients need to be aware of cultural differences between them and U.S. physicians, so they can better understand physicians and properly follow their advice. It is helpful for patients to learn about American culture by reading, interacting with Americans, and attending healthcare seeking training programs. They can also learn about the U.S. healthcare system and procedures by checking professional websites and consulting with medical staff at local healthcare services, thus preparing themselves for seeking healthcare in the U.S.

4.4.2 Actively and Accurately Provide Information to Facilitate Diagnosis

Since nurse practitioners usually collect patients’ health information before meeting the physicians (which does not occur in many other countries), it is helpful for patients to practice describing their basic information (e.g., self and family illness history, current symptoms) before visiting the hospital. They can also make a list of medications previously taken and keep relevant examination results handy for physician’s convenience. In order to provide information accurately, it is necessary for patients to
check for exact words in the dictionary before describing their symptoms. Rather than waiting for physicians to ask questions (which is a tradition in some countries), it is wise for patients to actively provide as much information as they can, because physicians cannot find out the problem until patients tell their stories.

4.4.3 Ask Questions As Needed

Patients need to realize that they have the full right to seek information from physicians as well. Since physicians might not be able to cover all the details that patients need, patients should feel free to ask questions. They can prepare a list of questions beforehand, which can include what medicine to take, and how to take it, possible side effects of the medicine, and how to deal with it. Besides, it is suggested that U.S. universities and communities provide programs that train international people in seeking healthcare in the U.S. and communicating with American physicians.
CHAPTER 5: CONCLUSION

Physician-patient communication training is a worthwhile effort to remove some of the cultural barriers between U.S. physicians and international patients. A great many studies have assessed such training programs as cultural competence training (CCT) and patient communication skills training (PCST). However, most CCT research focused on physicians/health learners’ training experiences over patients’ perspectives. In those that reported physicians/health learners’ improved knowledge of different cultural perspectives, a concrete illustration of their perceived cultural differences has not been provided. Despite a patient-centered perspective presented in PCST research, cultural competence and cross-cultural issues in physician-patients communication have rarely been addressed. As a result of absent study on international patients’ training experiences and cultural perspectives, although physicians can learn from previous research that cultural competence is important and physician-patient communication training is an effective tool to improve this skill, they could not directly gain knowledge about international patients’ perspectives or their desired communication manners.

In order to bridge the gap discussed above, this study examined a group of international patients’ experiences and cultural perspectives while participating in a cultural competency laboratory. Studying international patients’ perceptions can help physicians and health learners better understand patients’ needs, thus, providing more suitable recommendations and increasing patients’ compliance to suggested treatments. Great effort has been made to identify cultural differences that emerged during the lab and how these differences affected physician-patient communication. These observations
present situations and issues that physician/health learners may actually face in their clinical practice. Based upon the observations, suggestions proposed at the end of this study could help physician/health learners address similar issues. In addition to educating physicians, this study raised the critical need to improve international patients’ cultural awareness and cross-cultural communication skills.

During focus group and in-depth interviews, participants’ responses demonstrated that healthcare system and culture in a country fundamentally influence individuals’ health beliefs, healthcare seeking behaviors, and physician-patient communication. Significant cultural differences emerged during the cultural competency laboratory. The conflicts and negotiation between participants and student-physicians helped both parties improve their abilities to understand and address different cultural perspectives. Generally, participants established a stronger attachment with student-physicians who were welcoming and respected/understood participants’ cultural perspectives, and were able to show cultural empathy and provide culturally suitable solutions.

The cultural competency laboratory provided a lesson for physicians/health learners to realize that cultural awareness and cross-cultural communication skills are as important as medical skills. This training also helped international participants improve their knowledge about U.S. healthcare system and communication skills needed to interact with U.S. physicians. It is necessary for international patients to get prepared before visiting U.S. physicians and play a more active role in physician-patient communication. At the end, it is suggested that physician-patient communication
training, especially for international populations, be available in more U.S. university and communities.

Of course, this study is not without limitations. The primary consideration is the representativeness of participants. Because participants in this study were recruited from the lab participants, the sample size and background of participants were restricted by the lab recruitment process. Apparently, thirteen participants cannot represent the huge international population of diverse cultural backgrounds. Since these participants had a relatively good English proficiency as they study or work in the U.S. and had passed English proficiency tests, their education level and language proficiency cannot represent the actual situation of the general international population. Therefore, the purpose and function of this research was not to generalize a representative conclusion, but to explore diverse cultural perspectives carried by individuals through in-depth discussions. The findings of this study, although is a small piece of the whole picture, can hopefully provide physicians/health learners with some clues to refresh their awareness of international patients’ cultural backgrounds.
REFERENCES


APPENDIX A: CASE SCENARIO OF CULTURAL COMPETENCY LABORATORY

Patient Case:

You (the patient) went to a local family practice doctor (Dr. Smith) two weeks ago with feelings of fatigue and sadness. You haven’t been eating because you have no appetite and you don’t sleep well. You wondered what was wrong with you? Those around you say that you are irritable and not much fun. You haven’t felt concerned about how you look and have been staying to yourself and not talking to others the way you usually do. You don’t like Athens, but you must be here for several years. Your work here has not been going well.

Dr. Smith had a complete work-up done and when you returned a week late, Dr. Smith reported that everything was within normal limits. There was nothing physical that accounted for your fatigue, and you don’t appear to be suffering any physical illness. Dr. Smith wanted you to see a psychologist or psychiatrist because you seemed to be depressed and to return for a follow-up visit in 3 weeks.

To be depressed in your culture is not acceptable. You believe that this diagnosis will cause problems with your family, and you believe that it is wrong. There must be some physical problem that is making you feel tired. You didn’t want to see a psychiatrist or psychologist because you aren’t depressed, so you didn’t go.

You have returned to Dr. Smith for the follow-up appointment and you are asking for some medication to give you more energy.
APPENDIX B: PROTOCOL FOR THE FOCUS GROUP DISCUSSIONS

**Topic 1: Participants’ culture-related needs/expectations**

Q1: Prior to or during the lab interviews, what did you expect/need from the student-physicians?

Q2: Did the student-physicians pay attention to/take good care of your these needs/expectations? Please give examples to explain.

**Topic 2: Participants’ perceived cross-cultural issues during the lab**

Q1: What concerns or difficulties did you encounter while communicating with student-physicians in the lab?

Q2: What did you consider to be positive factors that facilitated your interaction with the student-physicians? Please give examples to explain.

Q3: What did you consider to be negative factors that discouraged your interaction with the student-physicians? Please give examples to explain.

**Topic 3: Participants’ suggestions for improving cross-cultural physician-patient communication**

Q1: Is there anything you would recommend to add or change in the lab in order to improve the cultural competency training of student-physicians?

Q2: What would be your recommendations/suggestions for student-physicians, and/or actual physicians, and/or international patients to improve their competence in cross-cultural physician-patient communication?
APPENDIX C: RANKING FORM

1. Based on your experience during today’s cultural competency laboratory, please write down three positive factors that you think facilitated the communication between you and the student-physicians. (No need to rank the factors in any certain order)

Positive factor 1:

Positive factor 2:

Positive factor 3:

Example(s) or explanation(s) to your above answer, if applicable:

2. Please write down three negative factors that you think discouraged the communication between you and the student-physicians. (No need to rank the factors in any certain order)

Negative factor 1:

Negative factor 2:

Negative factor 3:

Example(s) or explanation(s) to your above answer, if applicable:
APPENDIX D1: PROTOCOL FOR THE IN-DEPTH INTERVIEWS (DRAFT)

Topic 1: Participants’ culture-related needs/expectations
Q1: Prior to or during the lab interviews, what did you expect/need from the student-physicians?
Q2: Did the student-physicians pay attention to/take good care of your these needs/expectations? Please give examples to explain.

Topic 2: Participants’ perceived cross-cultural issues during the lab
Q1: What concerns or difficulties did you encounter while communicating with student-physicians in the lab?
Q2: What did you consider to be positive factors that facilitated your interaction with the student-physicians? Please give examples to explain.
Q3: What did you consider to be negative factors that discouraged your interaction with the student-physicians? Please give examples to explain.

Topic 3: Participants’ suggestions for improving cross-cultural physician-patient communication
Q1: Is there anything you would recommend to add or change in the lab in order to improve the cultural competency training of student-physicians?
Q2: What would be your recommendations/suggestions for student-physicians, and/or actual physicians, and/or international patients to improve their competence in cross-cultural physician-patient communication?
APPENDIX D2: PROTOCOL FOR THE IN-DEPTH INTERVIEWS (REVISED)

Demography: Participant’s name, country, major

Topic 1: Previous knowledge about the cultural competency laboratory

1. Was it your first time attending a cultural competency lab?
2. How did you originally learn about this lab?
3. Have you heard about something similar to this kind of lab before?

Topic 2: Previous medical visit in the U.S.

1. Before this lab, did you have chance to visit a doctor in the U.S.?
2. If yes, were there anything different seeing a doctor in the U.S. from your experience in home country? If yes, what are they? (e.g. medical system, doctor-patient relationship, doctor-patient communication, personal feeling)
3. Compared to your medical visit in the U.S., was your lab experience different? How?
4. Do you know anybody around you in your country that has depression? How did the doctor take care of this case?

Topic 3: Lab experience

General impression

When we talk about the lab again today, what was the most impressive/exciting thing about it that comes to your mind?

Expectations

1. At the beginning of the lab, did you have any idea how it might be?
2. Before talking to the student-physicians, did you have any expectation from them?
   (1) What kind of conversation did you expected to have with them?
   (2) What kind of help did you expected from them?
3. Was the actual situation like what you expected?

*Preparation*
1. Before seeing the student-physicians, how did you prepare for the conversation? (e.g. how did you use the script? Did you look at it all the time during the conversation?)
2. Did you change/adapt your strategy as the lab goes on? Did it work well?

*Feelings*
1. When you were waiting for the student-physicians, what was your feeling?
2. Did your feeling change during the lab?

*Real life storytelling*
1. During the lab we had a free chance to explain the physicians what happened in our life that we think might caused depression, did you ever try to bring your real life experience into the conversation?
2. If we put it in a precise way, say use a number, how many percentages you brought your real life story into the conversation?
3. What do you think of bring your real story into the lab? Was it helpful? Were you concerned if the student-physicians know it is your real experience?
4. When telling your real story, did you feel a strong attachment with the student-physicians? Was there a moment that you feel that you were not acting and you are really seeking help from a doctor?
**Difficulties/Concerns**

1. Did you have any difficulty communicating with the student-physicians during the lab? How did they help you with your problems?

2. Did you have any concerns while talking to the student-physicians? Did they take care of your concerns?

**Topic 4: Lab influence on participants**

**Emotion**

1. Since the topic was depression and we talked about depression the entire morning, what did you feel about it? Did the conversation affect your emotion? (Did you feel tired, or start feeling depressed?)

**Knowledge**

1. What was your idea about depression before attending the lab?

2. Do you feel your knowledge about depression changed after the lab?

**Evaluation of student-physicians’ performance**

1. During the lab, were there any student-physician did a good job that you really appreciate?

2. Were there any student-physician did not do very well or made you feel uncomfortable?

**Student-physicians’ cultural background & gender**

1. Did you meet non-American student-physicians? How were the conversations?
2. Do you think the student-physicians’ cultural background (which country they are from) matters to the physician-patient communication? Why?

3. Do you think the student-physicians’ gender matters to the communication? Do you prefer talking to a female/male foreign physician? Why?

*Satisfaction*

1. If there will be another lab in the future, would you like to attend? Why/why not?

2. Would you recommend this lab to your international friends? Why/why not?

*Topic 5: Suggestions*

*For medical students*

1. What would be your suggestion for student-physicians to improve their communication with international patients in future?

*For international patients*

1. Do you think it is necessary for actual international patients to get prepared before they see a foreign doctor? Why?

2. If yes, in what way you would suggest the international patients to get prepared?

*For your own major*

Do you think it is possible to borrow some ideas from this lab to create some kind of training for students in your major? What would be your suggestion?

*End*

I am done with my questions, is there anything you would like to add?
## APPENDIX E1: RANKING RESULTS OF POSITIVE FACTORS

<table>
<thead>
<tr>
<th>Positive Factors</th>
<th>Participants’ Ranking</th>
<th>Total ranks</th>
<th>Number of people ranked</th>
<th>Mean rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parties’ active listening</td>
<td>4 1 2 1</td>
<td>8</td>
<td>4</td>
<td>2</td>
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<tr>
<td>Students’ thoughtfulness</td>
<td>1 3 1 2 5</td>
<td>12</td>
<td>5</td>
<td>2.4</td>
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<tr>
<td>Students’ empathy</td>
<td>5 3 3 1 3</td>
<td>10</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>Students’ careness</td>
<td>2 1 5</td>
<td>8</td>
<td>3</td>
<td>2.67</td>
</tr>
<tr>
<td>Students’ awareness of differences</td>
<td>2 5 1 4</td>
<td>12</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Students’ being responsive to patients’ queries</td>
<td>3 4 2</td>
<td>9</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Students’ respect to patients</td>
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<td>4 4 2 10</td>
<td>3</td>
<td>3.33</td>
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<tr>
<td>Students’ using easy-to-understand language</td>
<td>2 4 5</td>
<td>11</td>
<td>3</td>
<td>3.67</td>
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<tr>
<td>Both parties’ awareness of cultural differences</td>
<td>5 5 2</td>
<td>12</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Students’ positive facial expressions and gestures</td>
<td>5 4 3</td>
<td>12</td>
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<td>Warm greetings from both parties</td>
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<tr>
<td>Students’ awareness of stigma attached to health issues</td>
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<tr>
<td>Students’ offering options to patients</td>
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<tr>
<td>Students’ willingness to help patients</td>
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APPENDIX E2: RANKING RESULTS OF NEGATIVE FACTORS

<table>
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<th>Negative Factors</th>
<th>Participants’ Ranking</th>
<th>Total ranks</th>
<th>Number of people ranked</th>
<th>Mean rank</th>
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<tr>
<td>Students’ being close-minded regardless of patients’ perspectives</td>
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<td>Students’ frequently checking their scripts</td>
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<td>2</td>
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<tr>
<td>Students’ being pushy to convince patients</td>
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<td>10</td>
<td>4</td>
<td>2.5</td>
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<tr>
<td>Students’ showing distance to patients</td>
<td>1 2 5</td>
<td>8</td>
<td>3</td>
<td>2.67</td>
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<tr>
<td>Students’ using too many medical jargons</td>
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<tr>
<td>Students’ fast English speaking</td>
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<td>Students’ making assumptions about patients</td>
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<td>4</td>
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<tr>
<td>Students’ lack of eye-contact with patients</td>
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<td>6</td>
<td>4</td>
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<td>Silence while both running out of words</td>
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<td>12</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Students’ inability to understand patients’ talking</td>
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<td>Students’ giggles at patients’ inquiries</td>
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<tr>
<td>Students’ having no physical checkup</td>
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*1, 2, 3, 4, and 5 refer to rank order of influential factors*