



## UvA-DARE (Digital Academic Repository)

### "What do you think I should do?": Understanding intercultural medical communication in general practice

Schinkel, S.

**Publication date**

2015

**Document Version**

Final published version

[Link to publication](#)

**Citation for published version (APA):**

Schinkel, S. (2015). *"What do you think I should do?": Understanding intercultural medical communication in general practice.*

**General rights**

It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

**Disclaimer/Complaints regulations**

If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: <https://uba.uva.nl/en/contact>, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.



## CHAPTER 6

### Summary and discussion

The aims of this dissertation were to unravel the differences between Dutch and Turkish-Dutch patients in the determinants of patient participation (willingness to participate, ability to participate and concordance) and the relationship between patient participation and communication outcomes (fulfillment of information needs, patient satisfaction and understanding of information) among these patient groups. Investigating the differences gains knowledge on why intercultural communication is less effective and less adequate than intracultural communication. The knowledge derived from this dissertation provides more understanding of intercultural medical communication and can be used to design effective interventions to improve the communication between Turkish-Dutch patients and Dutch doctors. The main findings of the four empirical studies in this dissertation will be summarized below, followed by a discussion of the findings.

#### **Information needs and communication outcomes**

Chapter 2 aimed to assess information needs and fulfillment of information needs among Dutch and Turkish-Dutch GP patients in the Netherlands. In addition, the relation between perceived and recorded information provision by GPs was studied. Unfulfilled information needs of Dutch ( $N=117$ ) and Turkish-Dutch patients ( $N=74$ ) were measured using pre- and post-consultation questionnaires. GPs' information provision was coded using the transcripts of 120 audiotapes of the consultations. The results showed that both Turkish-Dutch and Dutch patients reported high information needs. However, Turkish-Dutch patients preferred to discuss prognosis, prevalence, physical examination, medical terms, alternative medicines and procedures at other hospital/other caregivers more than Dutch patients. Turkish-Dutch patients also experienced more unfulfilled information needs than Dutch patients. Fulfillment of information needs among Turkish-Dutch patients was also affected by their acculturation levels. Turkish-Dutch patients who reported intermediate acculturation levels experienced worse fulfillment of information needs compared to patients who had lower or higher acculturation levels. Moreover, the results showed that perceived information provision was hardly related to the recorded information provision, suggesting that patients' perceived information provision during the encounter seems to be affected by something else than the actual provision by the GP. The overall conclusion of Chapter 2 was that Turkish-Dutch patients and, to a lesser extent, Dutch patients as well, are insufficiently provided with the information they prefer by their GP.

#### **Health-information seeking, patient participation and communication outcomes**

In Chapter 3 it was investigated how Dutch and Turkish-Dutch GP patients use media to prepare themselves for the consultation and how the groups differ in their participation during medical consultations with GPs. In addition, the relationships between media use and patient participation and between patient participation and fulfillment of information needs were assessed. Patients were recruited in the waiting rooms of their GP. In total, 191 patients (117 Dutch, 74 Turkish-Dutch) completed pre- and post-consultation questionnaires, from which 120 patients (62.8%; 82 Dutch, 38 Turkish-Dutch) agreed to have their consultations recorded. The 38 Turkish-Dutch patients were matched on age and gender with Dutch patients, resulting in 34 Dutch and 34 Turkish-Dutch consultations

to assess patient participation. Despite the fact that patients had similar educational level, the results showed that Turkish-Dutch patients used a wider variety of media to search for information. Dutch patients primarily reported to use the Internet, whereas Turkish-Dutch patients reported to also use books, magazines and newspapers, and television and radio. Turkish-Dutch patients also asked fewer questions, initiated fewer topics and responded to their GP to a lower extent during the consultations than Dutch patients. Among Turkish-Dutch patients, media usage was related to increased patient participation, and higher patient participation was related to better fulfillment of information needs. These relationships were not found among Dutch patients. The overall conclusion of Chapter 3 was that through interventions that stimulate ethnic minority patients in information-seeking behavior using media prior to their medical consultation, patients will enhance their participation resulting in better fulfillment of informational needs.

#### **Communication and cultural barriers for patient participation**

Chapter 4 was aimed at better understanding why Turkish-Dutch GP patients participate less actively during a medical consultation than Dutch GP patients. Four focus groups were conducted with Turkish-Dutch and four with Dutch participants ( $N=46$ ) assessing their perceived barriers to participate during an encounter with their GP. Separate focus groups were run for male and female participants, and Dutch and Turkish-Dutch participants were matched to each other on age, education and neighbourhood. Findings showed that, due to language barriers, Turkish-Dutch patients have difficulties understanding the information of the GP and were less able to participate and to express their health problems. Turkish-Dutch participants further reported stronger feelings of hierarchy with their doctor (more distance with the doctor, doctor having larger responsibility), higher uncertainty avoidance (struggling with the Dutch treatment approach in which several options are tried), and a more high-context, indirect communication style (more implicit style in which the message is picked up from the context) than Dutch participants. Turkish-Dutch participants also preferred a more personal doctor-patient relationship compared to Dutch participants; the doctor should be like a family member or friend. Language and communication style barriers seem to influence Turkish-Dutch patients' ability to participate, while cultural barriers seem to affect their willingness to participate. To conclude, cultural and communication differences hinder Turkish-Dutch patients to be active communicators during the conversation with their GP.

#### **The match between preferred and perceived patient participation and the role of the doctor-patient relationship**

In Chapter 5 it was investigated how doctor-patient concordance in preferred doctor-patient relationship and the match between preferred and perceived patient participation were related to communication outcomes among Turkish-Dutch and Dutch GP patients. 32 GPs (9.3% response) participated with questionnaires. 136 Dutch and 100 Turkish-Dutch patients (64% response) participated with pre- and post-consultation questionnaires, which were filled out in their GP's waiting room. GPs and patients answered the same items to measure their concordance in preferred doctor-patient relationship. The match between patients' preferred and perceived participation was calculated using pre- and post-consultation patient scores. The results showed that a match between preferred and perceived patient participation resulted in more positive communication outcomes among both Dutch and Turkish-Dutch patients. In addition, Turkish-Dutch patients who were discordant with their GP in preferred relationship and perceived high participation during

the medical encounter reported worse satisfaction, fulfillment of information needs and understanding of the information than those with lower perceived patient participation. Among Dutch patients, no effects were found for doctor-patient concordance. For Turkish-Dutch patients, better Dutch language proficiency also accounted for more satisfaction and better fulfillment of information needs compared to patients with lower Dutch language proficiency. Because concordance effects seem to be moderated by perceived patient participation among Turkish-Dutch patients, concordance studies should include perceived patient participation and should separate ethnic groups in the analyses to investigate the relationships between doctor-patient concordance and communication outcomes. For improvement of the intercultural medical communication, GPs should be trained to communicate in such a way that a match is established between a migrant patients' preferred and perceived participation during the encounter.

#### **Discussion and suggestions for future research**

The objective of this dissertation was to examine differences between Dutch and Turkish-Dutch patients in the factors determining patient participation and its relationship with communication outcomes in order to better understand intercultural medical communication. Specifically, the dissertation was aimed at answering the questions: (1) to what extent do Dutch and Turkish-Dutch patients differ in the factors underlying patient participation, and (2) how is patient participation related to the communication outcomes among Turkish-Dutch and Dutch patients? By examining differences between Dutch and Turkish-Dutch patients, inadequacies in intercultural medical communication can be better understood and more effective interventions to improve intercultural communication can be designed.

In the framework that was central to this dissertation (see Figure 1 in the Introduction) it was postulated that ethnicity influences the determinants of patient participation and that higher patient participation will result in better communication outcomes. The results of the studies provide clear evidence that differences exist between Turkish-Dutch and Dutch patients in the determinants of patient participation, in patient participation itself and in how patient participation is related to communication outcomes. The studies revealed new insights into the factors underlying patient participation and how participation affects the communication outcomes among Turkish-Dutch patients, which have important research and clinical implications and help to better understand the intercultural medical communication. First, the differences between the patient groups in the determinants of patient participation and their participation will be described, followed by the differences in how patient participation affects communication outcomes.

#### Differences in willingness to participate

The results of this dissertation showed differences between Turkish-Dutch and Dutch patients in their willingness to participate. Turkish-Dutch patients' willingness to participate is determined by an interplay of (1) information needs and (2) participation preferences, and (3) differences in cultural values compared to their Dutch doctor. As described in Chapter 2, Turkish-Dutch patients had similarly high levels of information needs as Dutch patients, but reported a higher need to discuss prognosis, prevalence, physical examination, medical terms, alternative medicine and procedures at the hospital/other caregivers. In Chapter 5, higher participation preferences were found among Turkish-Dutch patients compared to Dutch patients. Because higher information needs and participation preferences are considered to stimulate patients to become more participative (Street

et al., 2003), the high information needs and participation preferences among Turkish-Dutch patients cannot account for their lower participation levels compared to Dutch patients. For Turkish-Dutch patients, the willingness to express information needs and act on participation preferences—resulting in higher participation—seems to be hindered by cultural differences in power distance, preferences for a more personal relationship and a different preferred treatment approach than is common practice in the Netherlands. Turkish-Dutch patients who experience difficulties with their relationship with their GP and with the treatment approach offered by their GP, will have lower willingness to participate and will be less participative than would be expected by their information needs and participation preferences.

As was found in Chapter 5, Turkish-Dutch patients with matched preferred and perceived participation preferences reported more satisfaction, better fulfillment of information needs and better understanding of the information. Given the different preferences found among Turkish-Dutch and Dutch patients for information topics (Chapter 2), for the doctor-patient relationship and the treatment approach (Chapter 4), and for patient participation (Chapter 5), it seems plausible that not the level of preference (either high or low) determines their level of participation, but how well their preferences are met by their doctor. Future research studying patient preferences in intercultural communication should thus take into account the level of preference-matching instead of, or combined with, how much a patient prefers certain topics or certain behaviors in order to understand ethnic minorities' participative behavior and communication outcomes.

Turkish-Dutch patients with intermediate levels of acculturation reported the highest information needs and worse fulfillment of information needs. Hence, better integration into Dutch society will not automatically enhance their willingness to participate. More research is needed to understand the role of acculturation on patient participation and communication outcomes, especially among Turkish-Dutch patients with equal identification.

In addition, it could be important to include previous experiences with the doctor and the health care system when explaining ethnic minority patients' willingness to participate (Harrington, Noble, & Newman, 2004). Considering the higher unmet information needs, lower understanding of the information and lower satisfaction found among Turkish-Dutch patients, previous negative experiences with Dutch GPs might negatively affect Turkish-Dutch patients' willingness to participate in future consultations. Moreover, as Turkish-Dutch patients often compare experiences with the Dutch health care system with the Turkish one (Bäärnhielm & Ekblad, 2000), the possibly more positive previous experiences with Turkish doctors and the health care system in Turkey might negatively affect their willingness to participate in a Dutch encounter. Research in which experiences with a Turkish-Dutch doctor in the Netherlands and a Turkish doctor in Turkey are compared, will give more insight into the effects of cultural differences in communication style, doctor-patient relationship and the treatment approach among Turkish-Dutch patients. Because Turkish-Dutch doctors will probably adopt the Dutch treatment approach and might also adopt the doctor-patient relationship common in Dutch encounters, it can be investigated which effect accounts for positive communication outcomes more: communication styles, treatment approach or the doctor-patient relationship.

#### Differences in ability to participate

The results of the dissertation also revealed differences between Turkish-Dutch and Dutch patients in their ability to participate. The ability to participate among Turkish-Dutch patients is affected by an interplay of (1) insufficient Dutch language proficiency, (2) different

health information-seeking behavior than Dutch patients and (3) different communication styles compared to their Dutch doctors'. As described in Chapter 4, better Dutch language proficiency enhances Turkish-Dutch patients' ability to understand the GP and to express and explain their health problem, making it easier for patients to participate actively during the discussion with their doctor. In Chapter 5 it was found that Turkish-Dutch patients with lower Dutch language proficiency were less satisfied and reported worse fulfillment of information needs than patients with better Dutch language proficiency, suggesting that better Dutch language proficiency improves communication outcomes through enhanced ability to participate.

Regarding their health information-seeking behavior, Dutch and Turkish-Dutch patients differed in their media usage prior to the consultation. Chapter 3 revealed that Dutch patients primarily report to use the Internet to search for health information, while Turkish-Dutch patients reported the Internet, books, magazines/newspapers and TV/radio as important sources for searching health information as preparation for the consultation. The different media usage between the patient groups could be related to the level of satisfaction of patients, because patients' tendency to use media for information is higher when their level of satisfaction with the doctor is lower (Tustin, 2010). The wider variety of media usage found in Chapter 3 might thus also be related to more unmet information needs among Turkish-Dutch patients found in Chapter 2 and the lower satisfaction levels found in Chapter 5.

Another explanatory factor for the difference in media usage might be patients' motivation to use these media. Health information can be searched for actively, by deliberately seeking for information, or through passively receiving health information (Longo, 2005). The Internet will primarily be used when patients have an active need for information, while media such as TV and radio will provide patients with information in a more passive manner. Considering the wide variation of media used among Turkish-Dutch patients, these patients might have other motivations or a wider variation of motivations for health information-seeking than Dutch patients. Preliminary analysis on qualitative data—not described in this dissertation but based on the same data used in Chapter 4 (Schinkel, Schouten, van Weert, Kerpiclik, & van den Putte, 2014)—revealed that Dutch patients expressed their information-seeking behavior as a way to prepare to communicate better with their doctor (to express themselves better, to discuss the information with the doctor, to be more assertive), while Turkish-Dutch patients' motivations to seek for information were associated with wanting to know more about their problem and to prepare for how to explain it in Dutch during the encounter. Although sufficient Dutch language proficiency is a prerequisite for Turkish-Dutch patients to be able to use the information effectively during the encounter, their participation can be enhanced by stimulating them to search for information to use it in their discussion with the GP—with or without an interpreter. Future research should incorporate the motivations patients might have to prepare for the consultation in order to understand their behavior during the consultation and their communication outcomes afterwards.

The focus group study described in Chapter 4 revealed important barriers concerning the different communication styles of Dutch and Turkish-Dutch patients. For Turkish-Dutch patients, the direct and to-the-point communication style of their Dutch doctor is uncomfortable. Turkish-Dutch patients expressed a preference for a more indirect way of communicating, reflecting the high-context style often found in non-Western populations (Hall, 1976). This communication style is more indirect and implicit, in which subtle details should be picked up from the context in order to understand what is being said

(Gudykunst et al., 1996; Gudykunst, 1997). Given that sufficient communication skills are needed in order to participate actively, Turkish-Dutch patients' struggle with the Dutch communication style decreases their ability to participate. The different communication styles between Turkish-Dutch patients and Dutch doctors seem to result in more passive patients. It could therefore be interesting to investigate the effects of patients' and doctors' preferred communication style on the level of patient participation during the encounter further in future research.

Turkish-Dutch patients who lack Dutch language proficiency will have the lowest ability to participate in an encounter with their Dutch GP. When Turkish-Dutch patients have sufficient Dutch language proficiency, they could go beyond preparing for the consultation in language terms and might be able to seek for health information to prepare for a more active role during the consultation. When Turkish-Dutch patients reach this level of ability to participate, they still need to be comfortable with the communication style of their doctor to be able to use the health information during the consultation, and consequently become more participative. More research is needed on the interplay between these factors among ethnic minority patients and how interventions can get ethnic minority patients to the third level of the ability to participate, thereby enhancing their participation.

#### Differences in concordance

Contrary to previous research which found that doctor-patient concordance positively influenced communication outcomes (Kiesler & Auerbach, 2006; Krupat et al., 2001; Street Jr et al., 2008), the results of Chapter 5 showed that doctor-patient concordance did not affect communication outcomes per se. However, perceived patient participation moderated the concordance effects for Turkish-Dutch patients who were discordant with their doctor in preferred doctor-patient relationship. Given that a discordant patient's perception of higher patient participation decreased communication outcomes among Turkish-Dutch patients, communication outcomes might not be affected by the level of agreement between patients and doctors in their preferences but by the perceived concordance by the patient or by how well the patients' preferred and perceived participation are matched. The negative effect of patient participation for discordant Turkish-Dutch patients found in Chapter 5 could be explained by a lack of flow in the conversation. Chapter 3 revealed more monologues and fewer dialogues during encounters with Turkish-Dutch patients compared to Dutch patients, suggesting a worse flow of the conversation. Thus, Turkish-Dutch patients might think they participated highly when they asked some questions or expressed a few concerns, while the actual conversation between patients and GPs does not go well at all.

Given the positive effect of the match between patients' preferred and perceived participation, accommodating patient preferences in order to reach a match between preferred and perceived participation behavior for the patient might be a more important predictor of communication outcomes than doctor-patient concordance (Campbell, Auerbach, & Kiesler, 2007). A match between what patients prefer and perceive to get during the consultation regarding the communication style, doctor-patient relationship and treatment approach could have similar positive effects. To be more specific, a match between preferred and perceived communication style might be an important predictor of Turkish-Dutch patients' ability to participate, resulting in higher patient participation. Matches in preferred and perceived doctor-patient relationship and treatment approach might be important predictors of patients' willingness to participate as well. Given the results of all chapters together, these matches might not be independent determinants of

patient participation, but might function as prerequisites of the ability and willingness to participate among ethnic minority patients. Further research is needed to investigate the relationships between different kinds of preference-matches and a patient's ability and willingness to participate.

#### Patient participation and communication outcomes

Considering the differences between Dutch and Turkish-Dutch patients in the determinants of patient participation, it seems logical that the groups also differ in their level of patient participation. In Chapter 3, lower *observed* patient participation was indeed found among Turkish-Dutch patients than among Dutch patients. Turkish-Dutch patients asked fewer questions, contributed and responded to a lower extent during the encounter than their Dutch counterparts. The opposite was found though for *perceived* patient participation in Chapter 5. When asked about the perception of their participation during the discussion with the doctor, Turkish-Dutch patients reported a higher perceived participation than Dutch patients. The discrepancy between observed and perceived participation among Turkish-Dutch patients is interesting, suggesting that patients perceive high participation while the observations indicate otherwise. The discrepancy might reflect differences in frame of reference regarding communicative behavior such as patient participation. Given that Turkish-Dutch patients reported a higher preference for doctor-centered consultations in Chapter 5 and a higher power distance with the doctor combined with a preference for a more indirect communication style in Chapter 4, Turkish-Dutch patients are less likely to display higher participation levels than Dutch patients, as was found in Chapter 3. Their perceived participation might thus be related to other factors than their actual behavior, such as problems in the relationship with the doctor, misunderstandings during the encounter or not getting their preferred treatment approach. Further research is needed to investigate whether the discrepancy can be replicated among research in which both the perceived and observed participation of patients is measured.

Regarding the relationships between patient participation and communication outcomes, the results of Chapter 3 showed that higher observed participation among Turkish-Dutch patients was related to better fulfillment of information needs. A higher contribution to the conversation thus seems to enhance Turkish-Dutch patients' communication outcomes. In Chapter 5, a match between patients' preferred and perceived participation was found to improve the communication outcomes and higher perceived participation resulted in worse communication outcomes among Turkish-Dutch patients who were discordant with their doctor in preferred doctor-patient relationship. Thus, the positive relationship between observed patient participation and communication outcomes in Chapter 3 might indicate that these Turkish-Dutch patients matched their preferred higher participation. More research is needed to disentangle the effects of preferred and perceived patient participation on different levels to know what kind of match results in most optimal communication outcomes.

#### **Implications for patient participation theory in an intercultural context**

This dissertation contributes to the literature on intercultural medical communication by investigating the factors underlying patient participation and its effects on communication outcomes. First, Street's model on patient participation could be applied to ethnic minority patients in intercultural settings, but the model should be extended with variables relevant for intercultural medical communication, and needs to take into account the differences between migrant patients and their doctors more strongly. It is suggested to include the

cultural and communication differences found among Turkish-Dutch patients compared to Dutch patients. In addition to language proficiency and acculturation, specific preferences regarding information provision and patient participation need to be addressed, not in terms of the level of information needs and participation preferences but in terms of the match between a patient's preference and what they perceive to get from their GP during the encounter. Furthermore, motivations to search for health information should be incorporated too.

Second, the findings of this dissertation suggest that the concept of patient participation needs to be operationalized differently in intercultural settings. In the literature, patient participation is defined in terms of asking questions, expressing concerns and assertive utterances, and the more a patient behaves as such, the better the communication and health outcomes will be (Street, 2001). However, this notion of patient participation seems to be a Western view on patient participation; it assumes that migrant patients act as individualistic-oriented partners in medical communication, preferring assertive behavior and communicating directly. Considering the cultural and communication differences between Turkish-Dutch and Dutch patients, it is questionable whether this approach is most optimal for these patients and whether it is necessary to stimulate such behaviors. Patient participation needs more diverse aspects to take into account the variety in patient preferences. In this context, it might be particularly important to clearly distinguish patients' preferences for participation regarding information provision and their preferences for participation in the medical decision making process. Patients' preferences for participation in the information provision are generally higher and more stable than their preferences for participation in the decision-making process (Gaston & Mitchell, 2005; Kiesler & Auerbach, 2006). This distinction between information provision and decision-making is widely known in the literature, but the concepts are often used interchangeably, both considered as patient participation. Making this distinction seems even more relevant for non-Western cultures, for which medical decision-making is often the responsibility of the doctor and family, instead of the individual patient (Gaston & Mitchell, 2005). Because Chapter 3 revealed that Turkish-Dutch patients were the least participative in the decision-making part of the consultation, Turkish-Dutch patients might be more willing to participate in the information provision, but less willing to participate in the decision-making. More research is needed to investigate preference differences in these different aspects of patient participation among ethnic majority and ethnic minority patients to gain more insight into cultural differences in the level of patient participation. For future research it is recommended to simultaneously measure both aspects of participation but separate them for analyses.

In addition, a division in instrumental and affective participation is suggested. Although this dissertation found lower participation levels among Turkish-Dutch patients, observed with instrumental parts of the conversation such as question asking, taking initiative and responding to the doctor, another study found higher expression of emotional cues and concerns among Turkish-Dutch patients compared to Dutch patients (Schouten & Schinkel, 2015). Given that in intercultural encounters doctors tend to demonstrate less affective behavior (Ferguson & Candib, 2002; Schouten & Meeuwesen, 2006), this affective behavior should be taken into account more specifically regarding patient participation and its communication outcomes. Given the different communication styles and different participation preferences found in this dissertation between Dutch and Turkish-Dutch patients, their preferences to display affective behavior might be different than their preferences to display instrumental behavior. More research is needed to investigate how

patients' preferences for either instrumental or affective participative behavior affect the communication and its outcomes.

In medical communication, especially in intercultural context, patient participation needs to be interpreted as a behavior in which a patient expresses its preferences. This could be either a preference for assertive behavior or for more passive behavior. Higher patient participation should not involve more assertive behaviors as such, but should be an interplay of different aspects of participation and should concern the expression of preferences for all these aspects. Higher patient participation might involve expressing a preference for assertiveness in one aspect of participation but preferring passiveness in the other. To enable more nuance around the concept of patient participation in intercultural context, future research should explore the effects of ethnic minority patients' preferences for these different kinds of patient participation on their communication and communication outcomes.

Finally, it should be noted that when Turkish-Dutch patients are discussed in this dissertation, it explicitly refers to intercultural medical communication with migrant patients. These patients might be as participative in Turkey as Dutch patients are in the Netherlands. The lower ability and willingness to participate among these patients in an intercultural encounter could be more strongly related to migration problems rather than ethnic background as such, leading to barriers and discordances with their Dutch doctors, which might not be present when they consult a Turkish doctor in Turkey. It should therefore not be assumed that Turkish-Dutch patients' preferences and participative behavior in encounters in the Netherlands could be generalized to their preferences and behaviors in Turkey. Future cross-national research is suggested to investigate differences in preferences and participative behavior among Turkish-Dutch patients visiting a doctor in the Netherlands and a doctor in Turkey.

### **Methodological considerations**

The findings of this dissertation suggest some methodological considerations for the research field of intercultural medical communication. Although the quantitative chapters (2, 3 and 5) gave important insights into differences between Dutch and Turkish-Dutch patients in their needs, behaviors and communication outcomes, the qualitative chapter (4) revealed more barriers among Turkish-Dutch patients and new and more detailed insight into the barriers of intercultural medical communication. Given that intercultural medical communication research is still quite nascent, combining qualitative and quantitative methods is recommended to be able to better understand the differences found between ethnic minority and majority patients. Qualitative research methods might also be more suitable among people with a more high-context communication style such as Turkish-Dutch patients. Given their struggle with direct questions of the doctor, more research is needed to assess whether Turkish-Dutch patients also struggle with direct questions in questionnaires. Although the questionnaire used in Chapter 5 was pilot tested among Turkish-Dutch patients, the higher participation preferences and higher perceived participation might indicate interpretation differences between Dutch and Turkish-Dutch patients of the items or the response scale.

Data collection among ethnic minority patients was especially hard to accomplish for questionnaire research. For the focus group study, finding existing Turkish groups was relatively easy and participants were very willing to discuss the issues with each other. For the focus group study, the Dutch participants were much harder to recruit, because existing groups were harder to find and if found, they were less willing to participate

together. Given the collectivistic nature of the Turkish-Dutch culture, research in which the collective is addressed, such as in focus groups, seems more suitable for Turkish-Dutch patients than for the more individualistic Dutch patients.

Moreover, questionnaire research in medical settings faces a lot of obstacles. First, finding GPs to participate was a major obstacle. Second, patients were reluctant to take part in the questionnaire research, especially Turkish-Dutch, low-educated and low-literate patients. These people have a hard time understanding questionnaires and seem to have distrust in research, partly due to a lack of knowledge on research practice. Low-educated and low-literate Dutch patients often expressed worries about the GP receiving their answers, or about receiving different care after filling out the questionnaire. Turkish-Dutch patients also worried that their GP received their answers, but also expressed worries about the government receiving their signature or that the recording of the consultation will be shared through the Internet and become known in the Turkish community. Although distrust in research is hard to overcome, different kinds of consent could be considered to overcome the barriers among Turkish-Dutch patients. For instance, oral consent might suit this patient group better, but privacy and integrity issues have to be considered then. To overcome the difficulty in understanding questionnaires among low-educated and low-literate Dutch patients and Turkish-Dutch patients, different methods of collecting questionnaire data among these patient groups should be considered. Ideally, assistants could interview all patients. This way, patients do not require the cognitive skills of filling out questionnaires and the interviewer can explain things when necessary. However, this is more time-consuming and thus more expensive. A second option is using visual answer responses and/or recorded questions to which respondents could listen. With these methods however, practical issues such as lack of privacy in the waiting rooms leaves all kinds of logistic obstacles.

Furthermore, the studies in this dissertation involve GP patients, with a wide variety of health complaints and diseases. For Chapters 2 and 3 (using the same data set), we categorized the health complaints into the ICPC classification. Although there were no significant differences between the patient groups in health complaints, psychological problems seemed to be more prevalent among Turkish-Dutch patients. Differences between Western and non-Western patients in health issues are well known, such as a higher prevalence of type 2 diabetes mellitus (Uitewaal, Manna, Bruijnzeels, Hoes, & Thomas, 2004) and depression among Turkish-Dutch patients than Dutch patients (van der Wurff et al., 2004). Because a patient's needs and communicative behavior could be related to the health complaint, future research should take into account the complaint more precisely or setup the research around patients with a certain disease to investigate differences between patients with different health complaints in their needs and behavior.

Although this dissertation was primarily aimed at investigating differences between Dutch and Turkish-Dutch patients in their needs, behaviors and communication outcomes, the similarities between the patient groups as well as the differences within the patient groups should not be neglected. Among Turkish-Dutch patients, variation existed between people with high and low language proficiency or with certain acculturation levels. More research is needed with larger samples to investigate differences between first-, second- and third-generation Turkish-Dutch patients.

Finally, the different measurements used in this dissertation for preferred, perceived and observed participation illustrate the difficulty of measuring patient participation and the necessity of clear definitions and measurements. In a previous study (Schinkel et al., 2010)—not described in this dissertation—Turkish-Dutch and Dutch patients did not differ

in their preferences in decision-making when using the *Problem-Solving Decision-Making scale* (Deber, Kraetschmer, & Irvine, 1996). In Chapter 3, observed patient participation was measured, which revealed lower participation levels of Turkish-Dutch patients than Dutch patients. In Chapter 5, preferred and perceived participation in the communication was measured, using another scale (Lerman et al., 1990). In that study, Turkish-Dutch patients reported higher preferred and perceived participation than Dutch patients. These different findings might be due to the different measurements used for patient participation (Say et al., 2006) and imply that the research field needs to be aware of measurement bias. In order to compare research findings regarding patient participation, researchers should be more precise in their definitions of patient participation and in the measurement that is used.

### **Clinical implications**

The results of this dissertation give insight into potential elements that help to design effective interventions to enhance intercultural medical communication. Given the many barriers that Turkish-Dutch patients encounter during their medical communication, interventions in an intercultural context need to address all these barriers. Turkish-Dutch patients reported high information needs and participation preferences but seem to be hindered to act on these needs and preferences due to cultural and communication barriers. Although stimulating to prepare for the consultation could enhance Turkish-Dutch patients' participation, they need to be educated in the Dutch health care system to be able to use the information during the encounter effectively. When Turkish-Dutch patients are more aware of common practice in the Netherlands, frustration about the communication and anxiety that they are not treated similarly as Dutch patients might decrease.

More importantly, when Turkish-Dutch patients learn how to express their preferences during the encounter, a better match might be achieved concerning their preferred communication style, doctor-patient relationship, treatment approach and patient participation, leading to more positive communication outcomes. To enhance patients in expressing their preferences, tools can be helpful. An interesting tool is the "Health Communicator", developed by a GP in order to improve the intercultural communication. The tool is designed in such a way that the patient is able to answer questions about their health problem that are normally asked by the GP during the consultation at home, in the language the patient prefers. The GP receives the answers in Dutch before the consultation, which helps the GP to prepare for the consultation based on more accurate information from the patient himself. For low-literate patients, the questions and answers can be listened to. The importance of such tools is that they can partly overcome the language barriers of the patient. Although Turkish-Dutch patient with large language barriers will still need an interpreter during the consultation, the GP receives the answers of the patient instead of an interpreter. Such tools also have the potential to educate patients in the Dutch health care system by incorporating information about the GP's communication style, treatment approach and doctor-patient relationship into the tool. Research is needed to evaluate such tools and investigate its effects on patients' participation and the communication outcomes.

Stimulating patient participation should not involve stimulating initiative and assertive behavior per se. Turkish-Dutch patients need to be stimulated to express their information needs and participation preferences and to discuss their desired relationship with the doctor, treatment approach and communication style. When they are trained in expressing their preferences, the chance that GPs can better meet their patients' preferences increases. That kind of patient participation should be stimulated in order to strengthen the relationship and consequently enhance the communication and its outcomes.

Training and educating patients in expressing their preferences to be able to meet these preferences does not work without educating and training doctors as well. This dissertation suggests that doctors need to be trained in accommodating the preferences of their migrant patients better. Given that intercultural medical communication is often less affective and informative, both aspects need to be addressed in intercultural training for doctors. Given the results of Chapter 4, doctors should try to avoid direct questions to stimulate Turkish-Dutch patients to think or decide about the diagnosis and treatment on their own. Questions such as “What do you think I should do?” will lead to uncomfortable situations in which Turkish-Dutch patients will not be as participative as they prefer, leading to more negative communication outcomes. Instead, doctors need to communicate in a more indirect way to elicit their patients’ preferences. Adopting a patient-centered approach in which patient preferences are taken into account and accommodated, and in which patients are seen as unique individuals, seems crucial for improving intercultural medical communication (Mead & Bower, 2000). Combining patient-centered care with cultural competence will build health care systems in which the preferences of all patients are effectively addressed, also those of ethnic minority patients (Saha, Beach, & Cooper, 2008). Patient-centered communication should not be a luxury for Western patients, as it also improves ethnic minority patients’ communication outcomes (Henbest & Fehrsen, 1992). However, despite the benefits that are ascribed to both patient-centeredness and cultural competence, adopting either style is hard to achieve and hard to train in practice (Bombeke et al., 2010; Seeleman et al., 2009). Training cultural competence requires a complex set of knowledge, attitudes and skills for doctors to obtain and be aware of and need to be addressed in medical training (Seeleman et al., 2009). This dissertation contributes to this literature by providing insight into cultural differences between doctors and patients and the necessity of eliciting and accommodating patients’ preferences. Training in patient-centeredness and cultural competence should be incorporated in medical curricula to educate young doctors and intercultural communication should not be an optional course for practicing doctors but should be embedded in continuing medical education. While the research field of intercultural communication is still challenging, its necessity is clear, and researchers should continue to investigate how doctors can be adequately trained in strategies to improve intercultural communication.

### **Concluding remarks**

Intercultural medical communication is less effective than intracultural medical communication and needs to be improved in order to enhance communication outcomes and help diminish health disparities. This dissertation shows that language barriers are one of the many barriers Turkish-Dutch patients encounter during their medical communication and that these barriers hinder them to be effective partners in communication. In order to improve their communication, patients and doctors need to be more aware of the cultural and communication barriers in intercultural communication. Turkish-Dutch patients need to be educated in common practice within the Dutch health care system in terms of communication style, doctor-patient relationship and treatment approach and need to be stimulated to actively prepare for the consultation and to express their needs and preferences to increase the chance these needs will be fulfilled. Doctors need to be educated in the expectations and preferences of migrant patients and need to be trained in eliciting and accommodating their migrant patients’ expectations and preferences better. With more awareness and empowerment on both sides of the table, intercultural medical communication will improve, ultimately resulting in better health care for migrant patients.