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Patients' need for information provision and perceived participation in decision making in doctor-patient consultation: Micro-cultural differences between French- and Italian-speaking Switzerland

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ABSTRACT

Objectives: To explore micro-cultural differences in patients' need for information provision, perceived participation in decision making, and related concepts during the doctor-patient consultation between French- and Italian-speaking patients in Switzerland.
Methods: In 2012, 153 French- and 120 Italian-speaking patients with chronic low back pain (cLBP) were surveyed on their need for information provision, perceived participation in decision making, cLBP knowledge, psychological empowerment, and trust in their doctor. *T*-tests and regression analyses with interaction terms were performed.
Results: Results show that French- and Italian-speaking patients significantly differed in their participation in decision making, with French-speaking patients reporting higher involvement. Need for information provision was related to empowerment among French- and to trust among Italian-speaking patients. For participation in decision making, trust was the only related concept among French-, and cLBP knowledge among Italian-speaking patients. Significant interaction terms indicate a moderation of micro-cultural background.
Conclusion: Findings point towards differences in the relationships between individual patient characteristics (i.e. knowledge, empowerment) and relational doctor-patient characteristics (i.e. trust) and patients' need for information provision and participation in decision making between French- and Italian-speaking patients in Switzerland.
Practice implications: Doctors should be aware of these differences when dealing with patients of different micro-cultural backgrounds.

1. Introduction

The doctor-patient consultation is characterized by complex interpersonal relations between doctors and their patients [1]. These result from individual characteristics of both parties as well as the particular context in which they interact. Patients shape the medical consultation with their level of involvement, which may be limited to the need for information provision or extend to participation in the decision-making process [2]. There is empirical evidence that the active involvement of patients in decisions about their treatment plan improves patient satisfaction, adherence to recommended treatments, and health outcomes [3,4]. Engaging the patient in shared decision making has thus been advocated by health policy makers as the preferred model of doctor-patient consultation [2]. Nevertheless, it is important to acknowledge that not all patients desire to be actively involved during the medical consultation. Especially men, the elderly, and less educated patients seem to prefer a paternalistic model leaving decisions about their treatment and health to the medical expert [5,6]. In how far differences in the desire for patient involvement are determined by patients' cultural background, has yet to be understood [7].

The ongoing globalization process has fueled a number of studies on cultural differences and how they affect the medical consultation. Comprehensive literature reviews and a meta-synthesis have identified both quantitative and qualitative studies that examined the effect of cultural differences*within* medical consultations [8–10]. Schouten and Meeuwesen [9] conclude that ethnic minority patients are less verbally expressive and assertive within the doctor-patient consultation. But the question remains

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whether these forms of low involvement result from patients' cultural background *per se* or the fact that their cultural background differs from the one of the doctor [11–13]. Studies on cultural differences *across* medical consultations could help answer this question, but cross-cultural studies in medical settings did not yet receive noteworthy attention. In principle, two types of cross-cultural studies can be distinguished: studies that examine different patterns in the doctor-patient consultation across countries [14,15], and micro-cultural studies concerned with the same phenomenon within countries.

Studying micro-cultural differences within countries is critical as it is generally assumed that people from the same country also share the same history, language, world-views, beliefs, norms, values, and habits, all considered cultural indicators [16]. However, countries exist where these indicators do not always match. One example is Switzerland, born from the common wish of people of different mother tongue and different cultures to be united [17]. First empirical studies observed micro-cultural diversity in Switzerland in various health contexts such as organ donation, disease prevention, disease management, and health promotion [18–21]. In these studies, language is indicative of micro-cultural diversity. The consideration that language differences reflect cultural differences originates from the principle of linguistic relativity. Advanced by Sapir and Whorf, the principle suggests that language influences how people think and behave [22,23]. With this in mind, three main micro-cultures can be identified in Switzerland: the German-speaking, the French-speaking, and the Italian-speaking. Studies on micro-cultural diversity in Switzerland did not find any systematic patterns that would allow ascribing certain characteristics to its micro-cultures across health contexts.

The present study explores yet another health context, i.e. the doctor-patient consultation, with the aim to understand in how far differences in perceived patient involvement – more precisely their need for information provision and participation in decision making – are determined by patients' cultural background *per se*. In doing so, it fills the gap on micro-cultural studies across medical consultations on the one hand, and helps consolidate findings on health-related micro-cultural diversity in Switzerland on the other hand. Furthermore, the study focuses on cultural differences between the French- and Italian-speaking populations. In contrast to the German-speaking, both populations are considered rather homogeneous because of their Romance language, yet they differ in health-related attitudes and behaviors as previous studies in other health contexts illustrated [18,21]. With regards to the context of doctor-patient consultation we therefore ask:

RQ1: Do micro-cultural differences exist in patients' need for information provision and their perceived participation in decision making in the doctor-patient consultation between French- and Italian-speaking Switzerland?

Since an active involvement in the doctor-patient consultation is key to chronically ill patients and the management of their disease [24,25], this study examines micro-cultural differences in the involvement of a specific patient population, namely chronic low back pain (cLBP) patients. To our knowledge, it is the first study that looks at micro-cultural differences in Switzerland in the context of medical consultations, and no insights are at hand. We therefore do not pose a-priori hypotheses on micro-cultural differences in patients' need for information provision and their perceived participation in decision making. It is well possible that micro-cultural diversity in patient involvement among French- and Italian-speaking cLBP patients do not exist. However, differences may exist in the relationship between patients' need for information provision, perceived participation in decision making, and both intra- and interpersonal concepts linked to these two dimensions of perceived patient involvement.

Three concepts related to perceived patient involvement have been identified in the scientific literature: patients' health-related knowledge, psychological empowerment, and trust in one's doctor. Considered a dimension of health literacy [26,27], patients' knowledge about their disease is deemed to be positively associated with information exchange and shared decision making in the medical consultation [28–31]. Likewise, feelings of empowerment – including perceptions of competence and control [32] – are thought to be related to patient participation in the doctor-patient consultation [33–35]. Eventually, trust in one's doctor is said to be linked to patient involvement during the medical consultation [36–38].

Micro-cultural differences in the relationship between patients' need for information provision, their perceived participation in decision making, and the aforementioned concepts can be of two kinds: first, the type of related concepts may be different in the two micro-cultures, and, second, the strength of the relationships may vary. We therefore furthermore ask:

RQ2: Do micro-cultural differences exist in the relationship between patients' need for information provision and their perceived participation in decision making in doctor-patient consultation on the one hand, and patients' health-related knowledge, psychological empowerment, and trust in one's doctor on the other hand between French- and Italian-speaking Switzerland?

Although previous studies showed that health knowledge, psychological empowerment, and trust in one's doctor are related to perceived patient involvement, a lack of empirical evidence and theoretical insights make us hesitant to formulate a-priori hypotheses on the moderation of micro-cultural background, i.e. whether the relationships are stronger among French- or Italian-speaking patients.

2. Methods

2.1. Procedure

To answer our two research questions, we collected data from 273 cLBP patients in the French-speaking cantons Vaud, Geneva, and Fribourg (Switzerland) and the Italian-speaking canton Ticino (Switzerland). Between January 2012 and 2013 outpatients and inpatients were recruited through their healthcare providers with different expertise (rheumatology, physiotherapy, pharmacology, and neurosurgery). Three healthcare providers collaborated in the recruitment of French-speaking patients, ten in the recruitment of Italian-speaking patients. To be eligible for the study, patients had to meet the following inclusion criteria: (i) age 18 years or older, (ii) persistent low back pain for at least three months, (iii) pain not caused by cancer, systematic inflammatory disease, or fibromyalgia syndrome, (iv) and sufficient knowledge of Italian or French respectively. All patients signed an informed consent before they completed a self-administered paper-and-pencil questionnaire. Inpatients filled out the questionnaire in the hospital during a moment convenient for them. Outpatients filled out the questionnaire in the medical practice either after the medical consultation or at another time upon appointment. A study nurse or student assistant was present to clarify any comprehension problems and to collect the completed questionnaire. This procedure was approved by the cantonal ethics committees of Vaud and Ticino and the institutional review boards of the collaborating hospitals in Geneva and Fribourg.

2.2. Measures

The questionnaire contained self-report measures, none of them originally developed and validated in French or Italian. Hence, forward and backward translation by two independent