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Do Dutch doctors communicate differently with immigrant patients than with Dutch patients?

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Abstract

The aim of this study was to gain deeper insight into relational aspects of the medical communication pattern in intercultural consultations at GP practices in the Netherlands. We ask whether there are differences in the verbal interaction of Dutch GPs with immigrant and Dutch patients. Data were drawn from 144 adult patient interviews and video observations of consultations between the patients and 31 Dutch GPs. The patient group consisted of 61 non-Western immigrants (Turkish, Moroccan, Surinamese, Antillean, Cape Verdian) and 83 Dutch participants. Affective and instrumental aspects of verbal communication were assessed using Roter's Interaction Analysis System (RIAS). Patients' cultural background was assessed by ethnicity, language proficiency, level of education, religiosity and cultural views (in terms of being more traditional or more modern). Consultations with the non-Western immigrant patients (especially those from Turkey and Morocco) were well over 2 min shorter, and the power distance between GPs and these patients was greater when compared to the Dutch patients. Major differences in verbal interaction were observed on the affective behavior dimensions, but not on the instrumental dimensions. Doctors invested more in trying to understand the immigrant patients, while in the case of Dutch patients they showed more involvement and empathy. Dutch patients seemed to be more assertive in the medical conversation. The differences are discussed in terms of patients' ethnic background, cultural views (e.g. practicing a religion) and linguistic barriers. It is concluded that attention to cultural diversity does matter, as this leads to different medical communication patterns. A two-way strategy is recommended for improving medical communication, with implications for both doctor and patient behavior.

Keywords: Medical communication; Intercultural communication; General practice; Interethnic differences; Immigrants; Health care; The Netherlands

Introduction

The present study focuses on ethnic minority patients, immigrants to the Netherlands, and the relational aspects of communicative interaction during medical visits to the practice of their general

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practitioners (GPs). Although the effect of doctor characteristics (like professional attitude, personal style and sex), specific health care organizational characteristics and patient characteristics (sex, age, education) on medical communication has been shown in many studies, few have explored the nature of cross-cultural medical communication in great detail (e.g. Kiesler & Auerbach, 2003). In the Netherlands, about 15% of the population is foreign-born; the largest groups (9%) are non-Western (e.g. Surinamese, Turkish and Moroccan), and about 6% of them were raised in other Western countries.

Studies performed so far have revealed more misunderstandings between doctors and ethnic minority patients than Dutch patients; among the consequences for medical care, studies report more inappropriate use of health services (particularly out-of-hours use), a greater risk of incorrect diagnoses, lower compliance with the advised treatment and less satisfaction (Luijten & Tjadens, 1995; van Wieringen, Harmsen, & Bruijnzeels, 2002). These results are confirmed elsewhere (e.g. van Ryn & Fu, 2003; Saha, Arbelaez, & Cooper, 2003). On the part of the doctor, studies show that the workload is higher with large numbers of ethnic minority patients because of different ways of communicating, different demands and a higher frequency of patient consultations (Cooper et al., 2003; Luijten & Tjadens, 1995; Schellevis, Westert, de Bakker, & Groenewegen, 2004). The consultations with these patients are emotionally demanding, and the patient's reasons for the visit are often unclear (Gerits, Uitenbroek, Dijkshoorn, & Verhoeff, 2001; Nierkens, Krumeich, de Ridder, & Dongen, 2002). These described difficulties are partly due to the expectations, norms, beliefs and perceptions about health and health care of ethnic minority patients, which are different than those of Dutch patients (Kleinman, 1980; van Wieringen et al., 2002).

Success and failure of treatment are highly dependent on bridging the differences in these expectations between patient and physician, among other things (Cooper et al., 2003; Harmsen, 2003; Harmsen, Bernsen, Meeuwesen, Pinto, & Bruijnzeels 2005; Van Wieringen et al., 2002). To bridge the gap, effective communicative interaction between physician and patient is crucial. Reasons for non-effective communication is numerous. For interethnic communication the main reasons include cultural differences, linguistic discordance and educational level (Flores, 2005; Lillie-Blanton & Laveist, 1996; Van Ryn & Burke, 2000). In multicultural contexts, cultural differences may lead to differences and misunderstandings in discussing content and in framing the relational aspects of communication. Kirmayer, Groleau, Guzder, Blake, and Jarvis (2003) described the impact of cultural misunderstandings in terms of incomplete assessments, diagnoses and treatments for a multicultural urban population in Canada.

An obvious hindrance to intercultural communication is the frequent lack of linguistic understanding between doctors and patients belonging to different ethnic/cultural groups (for extensive reviews of the literature on this topic, see Ferguson & Candib, 2002; Flores, 2005; Jacobs, Agger-Gupta, Chen, Piotrowski, & Hardt, 2003). Linguistic barriers may lead to a number of negative consequences, such as increased chances of non-compliance, feelings of fear and despair, and problems in achieving rapport (Ferguson & Candib, 2002; Ramirez, 2003). The distinction between culture and language is an important one: in many studies which focus on African-Americans and Caucasian Americans—all English speakers—substantial cultural differences appeared. Other research has dealt with cultural as well as linguistic barriers, such as studies on Hispanic and Asian immigrants in the USA. In the present study, both aspects may play a role.

While research on intercultural communication problems in health care has been given attention in the United States and Australia, it has only recently entered the agenda in the Netherlands (van den Brink-Muinen, Bensing, van Dulmen, & Schellevis, 2004; Van Wieringen et al., 2002). The present study on intercultural medical communication was initiated to contribute to a better understanding of the underlying mechanisms crucial to improving intercultural communication in health care.

The aim of this study is to gain insight into the specific communicational characteristics of intercultural consultations at GP practices in the Netherlands. The emphasis will lie on the relational aspects of communication and not on the content. The research question to be discussed is: *Are there differences in the medical interaction patterns between Dutch doctors and immigrant patients compared to Dutch patients?*

Interethnic medical communication

Among the studies on the communicative interaction of ethnic minority patients and Dutch