Cahiers de l'ILSL, N° 28, 2010, pp. 95-115

Intercultural communication in healthcare: a duel or a duet?

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1. INTRODUCTION: EXPLORING AND DEFINING THE BASIC PROBLEM

DUE TO WORLDWIDE MIGRATION, physicians in Europe and North America commonly encounter more patients from different ethnic origins and cultural backgrounds than did their predecessors; and this has had important implications for healthcare, not only in presenting physicians with a variety of formerly 'exotic' medical symptoms and diseases, but also presenting them with differences in the way patients view their needs and the expectations they bring to the clinical encounter (Kleinman et al., 1978). While the prevailing attitude of Western medicine has shifted over the last thirty years to a mostly patient-centred model, focused on shared decision-making (Cegala et al., 2000; Cecil & Killeen, 1997; Edwards et al., 2003), one may wonder how this model fits with the attitudes of patients coming from culturally different backgrounds (Kleinman, 1980; Pachter, 1994; Harmsen, 2003). Besides the differences in healthcare systems (Payer, 1990), differences in the cultural background will also influence patients' expectations (Clemes et al., 2001). As research has shown, good quality of care must take into account the patients' perspective (Clemes et al., 2001; Harteloh & Verheggen, 1994). Moreover linguistic barriers between doctor and patient may further affect the healthcare process (Ferguson & Candib, 2002; Jacobs et al., 2006; Flores, 2005), compounded by the fact that, typically, ethnic minority patients in contemporary Western soci-

eties are relatively young, poorly educated, and have poor second language proficiency (Tesser et al., 1999).

Patients whose ethnic origin and/or cultural background is different from their GP's assess the received care less positively than patients from the same background (Cooper-Patrick et al., 1999; Murray-Garcia et al., 2000), the chief complaints deriving from communication problems (van Wieringen et al., 2002). Studies on cultural variation in healthcare have focused mainly on differences in communication style, depending on ethnic origin (e.g. country of birth) (Cooper et al., 2003; Harmsen et al., 2006). However, several studies have shown that ethnic origin per se is not as important a variable as differences in the cultural assumptions of the patient and the doctor in the evaluation of healthcare (Harmsen, 2003; Phinney, 1996; Hofstede, 1991). Since the patient's perspective is important, it is necessary to study the different cultural frameworks patients bring to the medical encounter and how the healthcare worker understands them.

It seems to be beyond doubt that one of the patient's most important needs is to understand and to be understood (Roter & Hall, 1992). Kleinman, for one, claims that reaching shared clinical reality by finding a means for the patient and doctor to transact their different explanatory models is important for good and effective care (Kleinman, 1980; Kleinman, 1983). According to Kleinman, explanatory models for understanding episodes of sickness differ, between the practitioner and the patient, in terms of "analytic power, level of abstraction, logical articulation, metaphor and idiom". (Kleinman et al., 1978; Kleinman, 1980). In Kleinman's view clinical reality is the totality of cultural defined views and beliefs about health and illness. Kleinman takes the view that health complaints and illness are strongly culturally defined and that patient and physician differ in their cultural concepts of health and illness. According to Kleinman, both physician and patient need to find a way to translate each other's perceptions about patient's illness (each other's 'explanatory models') in order to achieve understanding (and consequently maybe also agreement) about diagnosis and treatment (Kleinman, 1980). Without understanding, we can assume both that the physi-

cian will have a higher rate of error in diagnosis and that there will be less compliance and a reduction in perceived quality of care on the part of the patient (Brown & Segal, 1996; Penn et al., 1995). This is of course true even when patient and physician share the same cultural background. For example, in English there are two words for sickness: illness and disease. Where illness is the experienced sickness as the patient perceives it, disease is the sickness as known by the physician, an explanation in biomedical terms. It is obvious that when physician's and patient's own cultural backgrounds are distant, mutual understanding about health complaints and illnesses will be more difficult to achieve and will require more mutual explanation of their views on health and illness in order to realize a shared concept of clinical reality.

In order to explore Kleinman's suggestions and to test the practicability of exchanging information on explanatory models, we performed two pilot studies using qualitative methods. In our first 1996 study (Harmsen et al., 1999), we investigated whether we could observe differences in communication in consultations with ethnic minority patients in comparison to consultations with Dutch patients in Rotterdam. The majority of ethnic minority patients in Rotterdam are from non-Western countries as Turkey, Morocco, Dutch Antillies, Surinam and Cape Verde. We found that consultations with ethnic minority patients were shorter, and ended more often in the prescription of medication. This appeared to be especially true for the consultations with non-Western patients. Bluntly and simply, the consultation with Western patients tended to be warm and conversational, while those with non-Western patients tended to be short and end with prescribing medication.

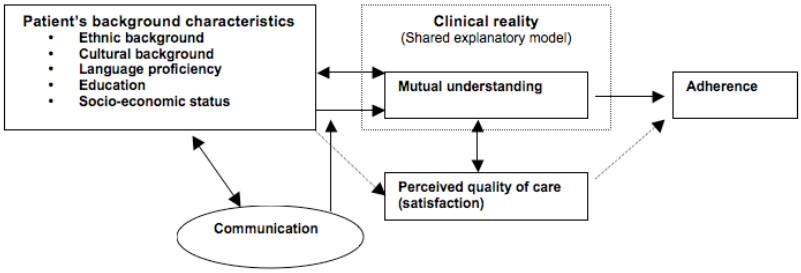
In our second pilot study, we constructed a measure for Kleinman's shared clinical reality that we called mutual understanding (van Wieringen et al., 2002; Harmsen et al., 2003). According to Helman (Helman, 1998), clinical reality is mostly determined by opinions about the origination and cause of health complaints, its meaning and severity for life, and its effect on life expectancy. We asked both physicians and patients questions about the nature and duration of

the health complaint, cause and severity, self diagnosis and desired cure.

Answers were compared by two researchers and measured in the degree to which they expressed good or poor mutual understanding. The two researchers discussed the consultations about which they disagreed until agreement was reached (or otherwise a third screener was consulted). Mutual Understanding (MU) is the understanding on both sides of each other's opinion on the health and illness issues. In 34% of the consultations with ethnic minority patients and in 13% of the consultations with Dutch patients there was poor MU. This turned out to be the best predictor of non-adherence (or non-compliance) to advised therapy. In other words, MU was a better predictor for adherence to therapy than patient's ethnicity: when adjusted for MU ethnicity disappears as predictor for non-adherence to therapy (tested in a logistic multivariate model). In this relatively small study (87 consultations), Kleinman's theory was validated (Harmsen et al., 2003). Later we developed a more sophisticated and objectivable measure for MU.

Still it remains complicated how to interpret adherence to advised therapy. Certainly the greater the degree to which quality of care is perceived, the greater the likelihood that the patient will adhere to the therapeutic regime. This perception of quality is probably a result of good MU, which in turn may be the result of communication. However, it is arguable that a perceived good relationship is the grounds for good communication or the other way round good communication provides good relationships. This is indicated in the figure 1 below.

Figure 1. Model for intercultural patient-physician communication and consultation outcomes



What this study also shows is that variables of influence like education and language proficiency influence MU directly or at least indirectly by communication.

Another factor of influence is of course the role of the physician, as the important and probably 'leading actor' in the conversation. In our large 2000 study (Harmsen et al., 2008), we divided the patient perception of the quality of care into two categories: perceived quality of the experienced relationship (Process Quality or PQ); and the quality of the experience mediated by the ethnicity of the actors involved (the specific Ethnic Quality or EQ). Less than 7% of the variance in Process Quality (PQ) and less than 1,5% of the variance in Ethnic Specific Quality (EQ) was explained by the difference between physicians.

Of course, different physicians will operate differently, but in relation to our scales we attempted to pick out information that would show if physicians communicate for the most part with the same rate of success, firstly, and secondly, whether there are other factors distinguishing clinical interaction that may override physician communication (idiosyncratic patient factors, the perceived severity of the presented health compliant, etc). Both PQ and EQ were measured on validated scales (El Fakiri & Weide, 2000). When patients were asked to give an overall global mark for the perceived quality of the conversation, 9% was explained by inter-physician variance. Thus, the global feeling of satisfaction of the consultation by patients is more physician-related than the more specified opinion

about physician/patient relationship asked according to our two other scales. The perceived ethnic/cultural related attentiveness is barely related to the particular physician by patients, making the communicative relation through which the patient and the clinician achieve mutual understanding (MU) during the consultation even more confusing.

But even if the quality of personal communication seems to be an opaque factor in the achievement of MU, still, the degree of MU using our rough scales does predict adherence to advised therapy best, which in turn is related to the perception of the quality of delivered care. To understand the concept of mutual understanding, we must have a better grasp of how it is constructed in real time medical communication. First, it evidently requires that that the physician understands the patient's opinion (and way of expressing an opinion) about the health complaint, its cause and perceived severity, the patient's hoped for cure, and what the patient expects from the development of the therapy. Second, the patient must also have an understanding of the physician's opinion (and the way the physician expresses himself) about this complex of factors. Analytically, these two poles of the dialectic of MU require understanding on both sides: one side – the patient or the physician – cannot bear the entire burden of understanding. Consultation is a mutual performance.

2. DEVELOPMENT OF A MUTUAL UNDERSTANDING SCALE

In our trial we refined the construction of the measure of MU to make it more objective and theoretically transparent than in the pilot study. We did this by asking patient and physician alike similar questions about the consultation afterwards (Harmsen et al., 2005). The questions were organized to correspond to the four phases in the consultation as they have been developed in medical education and training (Tange, 1996; Werf, 1996): 1) salutation and presentation of the health complaint, called the subjective aspect (S); 2) gaining

objectivity about the presented health complaints from transcribing the complaint and physical examination (O); 3) the diagnosing or analysing aspect (A); and 4) the prescription of a treatment, the giving of advice or the therapeutic plan (P). Because in Kleinman's theory a person's clinical reality also depends on his view about the causes of health complaints and illness, we added questions about the cause of the health complaint, which we labelled the (C) aspect. Thus five consultation aspects (C-S.O.A.P.) were used to assess MU. We tried to ensure that similar questions about these aspects were posed to both the patient and the GP. We used an open question format in regard to the C.S.A. aspects (again, for both patients and physicians) while questions about the phases O and P were answered with yes/no from a list of alternatives. We assessed the MUS (mutual understanding scale for health care) by comparing the answers of the physician and patient to questions about all C-S.O.A.P aspects. Two screeners assessed the level of MU reflected in the open questions, following instructions from an expert panel. The closed questions (yes/no) were compared by computer. In both cases we sought blind comparisons for physician, patient and consultation characteristics. And by comparing all the answers (of physician and patient) of all the questions together, we were able to construct a more realistic scale (Harmsen et al., 2005).

2.1. PATIENT BACKGROUND CHARACTERISTICS

We asked the patients as well to answer questions about their background characteristics, for which we developed a measure. In order to assess the language proficiency, ethnicity, income and education of patients, we asked for this information 3-5 days after the consultation, in a home interview (Harmsen et al., 2005). We asked for the patient's self-assessment of language proficiency in Dutch; we also asked for the self-assessment of ethnicity and the parental country of birth. We categorized ethnicity under the broad binaries of Dutch/non-Dutch, and Western/non-Western. Patients from: Europe, USA and Canada, Australia were considered to have a Western

background and patients originating from other countries we assigned to the non-Western category.
Education was assessed by highest accomplished education. We also asked for self-assessment of income.
Because we expected that ethnicity would only give us an imprecise measure of the patient's cultural background, we developed a separate measure for it.

2.2. Development of a Patient Cultural Background scale

We asked all patients questions on topics that were coded for cultural variation. We relied on earlier studies in the Netherlands to generate the questions that covered cultural-specific views and norms to fill out our cultural background categories (Dagevos, 2001; Martens, 1999). This generated a list of items about the general orientation toward society in four dimensions: male/female role patterns, individualism, secularisation, and alternative opinions. We then constructed and validated a scale using the modern-traditional binary to categorize views and opinions, which we called the Patient Cultural Background scale or PCB-scale (Harmsen et al., 2006).

2.3. Relation between PCB, degree of mutual understanding, and perceived quality of care.

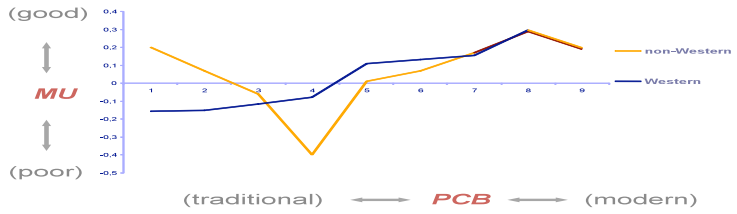
Because we expected the person of the physician to influence the outcomes, all analyses were done as multilevel regressions, taking the influence of the physician into account. We analysed all patients (Dutch and non-Dutch) together.
In order to discover which patient background characteristics were of influence on MU, we performed stepwise multilevel multivariate regression techniques to assess them. For MU we found that patient's educational level, patient's language proficiency, patient's ethnicity (defined by the Western/non-Western binary) and the patient's cultural background (PCB scale score) were the salient influencing background characteristics. In our analyses for MU we discovered that it was a matter of indifference whether we put the pa-

tient's ethnicity or PCB-scale score in the model: both gave almost the same score (Harmsen et al., 2005; Harmsen et al., 2006).
With regard to the patient's perceived quality of care, we used the process scale (PQ: regarding the perceived physician-patient relationship). This scale was assessed for all patients (Dutch and non-Dutch). We found the following factors had the most influence on the perceived quality of the physician-patient relationship: the patient's age, language proficiency and cultural background (PCB scale score) (Harmsen et al., 2006; Harmsen et al., 2008).
Thus, our general finding about the patient side of clinical communication – in so far as it is modelled by MU – is that the patient's language proficiency and cultural defined views play an important role in consultation, while the patient's educational level and age play a somewhat lesser one. In this framework, the patient's gender and income had no significant effect.
That the patient's language proficiency is important is obvious, but this was not the primary aim of our study, since we are concerned with the influence of the cultural difference separating the physician and patient in the instant of consultation. However, I will have more to say about the influence of language proficiency later on in this paper.

2.4. Relationship between Mutual Understanding and Patient's Cultural Background (MU and PCB)

We found that this relationship was different for Western as opposed to non-Western patients. As can be seen in figure 2 below, the most traditional non-Western patients scored as well in their consultation with the physician on MU as the most modern non-Western and Western patients. However, the 'intermediate cultural group' of the non-Western patients (partly traditional/partly modern) scored the most poorly on MU in their consultations with the physician. For the Western patients the relationship between MU and the PCB scale was more or less linear.

Figure 2. Relationship between Mutual Understanding and Patient Cultural Background scale for Western and non-Western patients separately



For all the members of the most 'modern oriented patients' (regardless of the Western/non-Western distinction), the score on MU with the physician was similar but declined somewhat. The reason why this happened is unclear, we can only speculate about it. Maybe when physician and patient are of the same cultural and educational level they both assume MU too easily or disagree more on viewpoints. More research should clear this phenomenon.

To explain these findings, we observe the following regarding the consultations of the non-Western group of patients. The 'intermediate cultural group' (partly traditional and partly modern) consists of migrants who have lived for a longer period (>10 years) in the Netherlands, as well as second generation migrants, who were born in the Netherlands. One might assume that this experience would lead to a lessening of the distance between the models of understanding employed by the patient and the physician, but this turns out not to be so. Why? Perhaps further study will show that in these cases, the physicians made pre-emptive decisions concerning the closeness of the patient's explanatory model to their own, and adapted their communication to that intuition. Justifications for this hypothesis come from the fact that we found a similar trend for Western and non-Western patients for their PCB score in age and education. Younger people appeared to be more 'modern' than elder ones and educated people more 'modern' than less educated. But compared with Western patients, non-Western patients scored within each comparable age or educational category as more traditional on the PCB scale. In other words, those patients who scored highest on the

highest on the non-Western scale have more traditional views, although the trend with age and educational level is similar to Western patients. So probably the physician took them (the second generation migrants and patients that stayed for a longer period in the Netherlands) to be more modern than they were, in fact, and adapted his (her) communication to a too 'modern level'.

Another reason for miscommunication for this 'in-between cultural group' may be the phenomenon that people tend to use their primary modes of understanding when they are under stress. Medical issues are often stress related and cultural level of functioning could very well regress to an older level under this 'medical stress related issues'.

Whatever the reasons, the fact remains that the 'intermediate cultural group' (partly traditional and partly modern) of the non-Western patients is the group most prone to present and receive explanatory models in their interactions with the physician that have a lower MU score – which means, as well, that physicians on the other side of the communication channel have a lower MU score for these patients. Thus, physicians should be very attentive to the assumptions they make about this kind of patients in the course of clinical communication.

To conclude: second generation and somewhat more acculturated patients are the patients for whom there is a greater risk of non-adherance to the therapeutic regime and lower perception of quality of care due to a lower degree of MU. Physicians should pay attention to this fact. At present, nothing in our findings allows us to definitely point out the mechanism driving this complex issue. More research is called for.

3. HOW TO IMPROVE MUTUAL UNDERSTANDING IN MEDICAL CONSULTATIONS?

Given our findings, we now are in a position to throw some light upon the complicated mechanism of Kleinman's theory, such as we

presented it in figure 1 (Kleinman et al., 1978; Kleinman, 1980; Kleinman, 1983). The question is not merely theoretical, having a bearing on how to improve therapeutic outcomes in a multi-cultural practice. To effectively improve the exchange of explanatory models between physician and patient, intervention to improve the communicative channel in consultations should be undertaken to educate both sides, physician and patient. After all you cannot communicate alone. In the end, the patient and physician have a largely shared interest and responsibility that is encoded in the efforts to achieve successful communication. However, one should remember where the power lies in the clinic: it is the physician who mostly directs the communication and must be regarded as the most powerful party, due to the hierarchy of medical institutions, the advantage in educational level and medical knowledge, and by the fact that he (she) is the person who determines the variables (time, place, methods) of the consultation.

The main emphasis of any intervention should therefore be raising the communicative consciousness of the physicians. Additionally the physician is the only person who stays the same in all his (her) consultations, while patients are an informal and disparate group, one that is harder to reach.

In our study we chose to study the consultations of General Practitioners (GP) or Family Physicians. Characteristically, patients are given short consultations by their GP, although short visits may occur frequently over long periods. This structure ensures that GPs will generally possess a more informed sense of the background and context knowledge of patients than other, specialized physicians, while patients will acquire the same kind of contextual sense of their physicians. We performed a randomised controlled trial with a double intervention (both GP and patient) (Harmsen, 2003; Harmsen et al., 2005). The intervention for the GP's consisted in a 2½ day course on intercultural communication, based on Pinto's 'three step method' (Pinto, 2000; Pinto, 2004). In the first step, the GPs were encouraged to reflect on their own culturally-defined norms, views and communication style. Second, we aimed to improve sensitivity and knowledge about culturally-determined differences in views and

behaviour (including communication style) in patients originating from non-Western countries or having other than Western cultural contexts. Third, we taught GPs to train themselves (using self chosen strategies) to solve the gaps in views and culturally-defined communication style. Two weeks later (in a final training session), problems that the trained GPs encountered were discussed and supplementary advice was given.

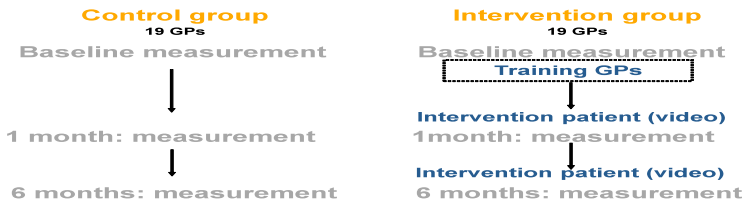
The patient intervention consisted of a 12-minute videotaped instruction in the waiting room for all patients immediately before the consultation; the videos were available in the language of the major ethnic minority groups (Moroccan-Arabic, Moroccan-Berber, Turkish and Dutch). The main message conveyed was to instruct patients to communicate directly and to express freely any misunderstanding and disagreement. In the video, two scenarios were shown, one with unsatisfactory and indirect communication, and one with satisfactory and direct communication.

To measure the effectiveness of these interventions, we conducted home interviews of the patients and had the GPs fill out questionnaires. Blinding the GPs for the intervention was impossible; after all it was a training. However, we did ensure that interviewers, experts and research assistants, who did preliminary data processing, were blinded for the intervention assignment and for patient or physician characteristics. Patients were not informed about their group assignment. GPs with a practice population of at least 25% patients with a non-Western country of origin were invited to participate, by letter and by one repeat request by telephone. Inclusion criteria for the patients were a visit to their GP for a consultation on random days in February, May and November 2000 (in which months each general practice was visited once for measurement); we excluded adolescents aged 12 and 17 years due to problems having to do with parental consent and the nature of our questions. As I indicated above, from our measurement we constructed background characteristics of patients and assessed MU.

First (February) we measured at our baseline, and then we performed the intervention for the GP's in the intervention group. Before the second and third measurement, we made sure that the pa-

tients of the intervention group received the video-instruction directly before the measurement was made (see figure 3 below).

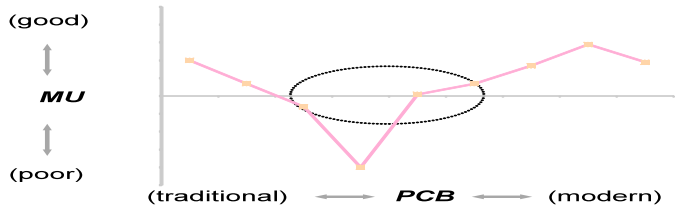
Figure 3. Design of the intervention study



We found that the intervention was not most effective directly after the GP intervention at the second measurement, but rather six months later at the third measurement, when we observed that consultations with non-Western patients saw a significant improvement in MU (13%) from baseline measurement in comparison with the control group, where no improvement was seen. We attribute the gap in the improvement curve (improvement appears only 6 months after the GP intervention) to the fact that changes in attitude and communication need time for implementation, as new insights have to be adopted and new skills practiced. That improvement occurred only in the non-Western patient group is in line with the nature of the intervention.

Significantly, the biggest improvement occurred in the intermediate cultural group of patients (partly traditional and partly modern), which was the patient group with the poorest MU with their GP (see figure 4 below).

Figure 4. Improvement of MU for intermediate cultural group



The MU measured with regard to the consultations of this intermediate group of patients improved 19%.
Thus, our result is that intervening in the physician-patient communication is effective and results in a better MU, entailing a better quality of the consultation.
A corollary result is that the perceived quality of care by patients improved in the same way.

3.1. INTERPRETED CONSULTATIONS

Because MU and perceived quality of care are strongly related to the patient's language proficiency, it is evidently necessary to pay attention to lack of language proficiency. When there is insufficient common language during the consultation, an interpreter should always be called in. But, on a cautionary note, in these cases, we should expect complications and many communication pitfalls, since a third party always adds quantitatively to the complexity of the conversation.
Interpreters can be formal (qualified, trained interpreters) and informal (bilingual family-members or friends, etc.). In our study we included some interpreted consultations, mostly with informal interpreters, which are quite common in GP consultations. But it is obvious that in general formal interpreters guarantee a higher level of translation quality than informal interpreters. Informal interpreters are mostly preferred for practical reasons (for instance, the comfort

the patient feels with a close associate or family member), which is why they are so common in general practice consultations, despite the fact that generally formal interpreting (often by phone) is easy and freely accessible in the Netherlands. However, sometimes, especially with unusual languages, availability of formal interpreters is a problem.

The double function of the informal interpreter as both translator and supporter is sometimes confusing for the interpreter and can bring about conflict of interests, especially when the issues involved are complicated or sensitive for family members (as in sexual and relational or marital problems and end of life issues). Next to personal and cultural dilemmas, it is sometimes difficult to find equivalent terms or concepts for both the terminology of the patient and of the physician. One should also keep in mind that the proficiency in the language of the country of origin of the second generation is sometimes not fully adequate. Also in a three-party conversation, side talk between two parties (interpreter physician or interpreter patient) tends to complicate the consultation. Formal interpreters are trained to minimize side talk, but informal interpreters tend to fall into this trap. As our study shows, side talk activity was a risk factor for poor MU.

3.2. PATIENT PARTICIPATION DURING THE CONSULTATION

Another finding of the trial was that the duration of consultations with non-Western patients was shorter than consultations with Western patients. Analyzing the videotaped consultations (with the Roter Interactional Analyzing System or RIAS) (Roter, 1991), we found that the average speaking time of the physician was the same in consultations with Western and non-Western patients (Meeuwesen et al., 2006), but that the speaking time of patients differed a lot, as non-Western patients took less time to express themselves than Western patients. Also, they did not argue or converse as much as Western patients (Meeuwesen et al., 2006). This finding points to a further factor to be aware of on the part of the physician, who should ask and stimulate non-Western patients to put their questions,

express their anxieties, and to speak up when they don't understand or disagree. But on the other hand this may not be 'cultural customary' and may be perceived adversely by the patient. Other factors that should be on the mind of GPs with a multi-cultural practice is to look out for the sometimes deficient knowledge of body functions on the part of non-Western patients, mainly due to a high percentage of illiteracy. As contemporary medicine has turned more and more towards prevention, which requires strong patient participation, a level of education in basic physiological facts should be assumed by the physician given indications of lack of comprehension during the consultation, with the aim of bringing patients up to a level at which they can negotiate equally with the physician.

This places the physician before a difficult choice: on one hand he (she) wants to reach good MU with the patient and may therefore fall into the role of unilaterally directing the patient in his (her) communication, and on the other hand there may be the wish to deliberate more with the patient and ask for the patient's opinion on issues posed to him (her). This may often be too big a challenge for the parties in the consultation space, which points to the need to employ other methods outside the consultation time proper to enlarge patient participation during the course of his or her consultations. Educational programs that can reach the non-Western migrants easily could be used for this purpose. Also the use of migrant link workers can help in this perspective (Bruijnzeels et al., 1999; Shapiro & Lenahan, 1996; Uitewaal, 2003). Because migration has become a social fact for our time and, in all probability, will remain so in the future, efforts to improve MU for physician and patient, requiring qualitative research to distinguish best practices, is and will be necessary to bring care for non-Western migrants to an acceptable level. The finding in this paper that should be underlined is that the more acculturated (e.g. second generation) migrants are not necessarily prepared to achieve a higher degree of MU than their parents or other, newer migrants, and that this presents us with a problem that must be solved through better awareness and education. This is as well an ethical item as a matter of public health, because there are enough (recent and older) studies proving poorer

objectifiable health conditions for non-Western migrants (Uitewaal, 2003; Agyemang et al., 2005; Mackenbach & Stronks, 2004; Porsch-Oezcueruemez et al., 1999; Reijneveld, 1998; van Steenbergen et al., 2001; Swart et al., 2002). Perhaps, after all, consultation should be neither a duel nor a duet: rather, it should be informed, caring, and solution oriented. Programs that aim towards this goal will serve patients and the community best.

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